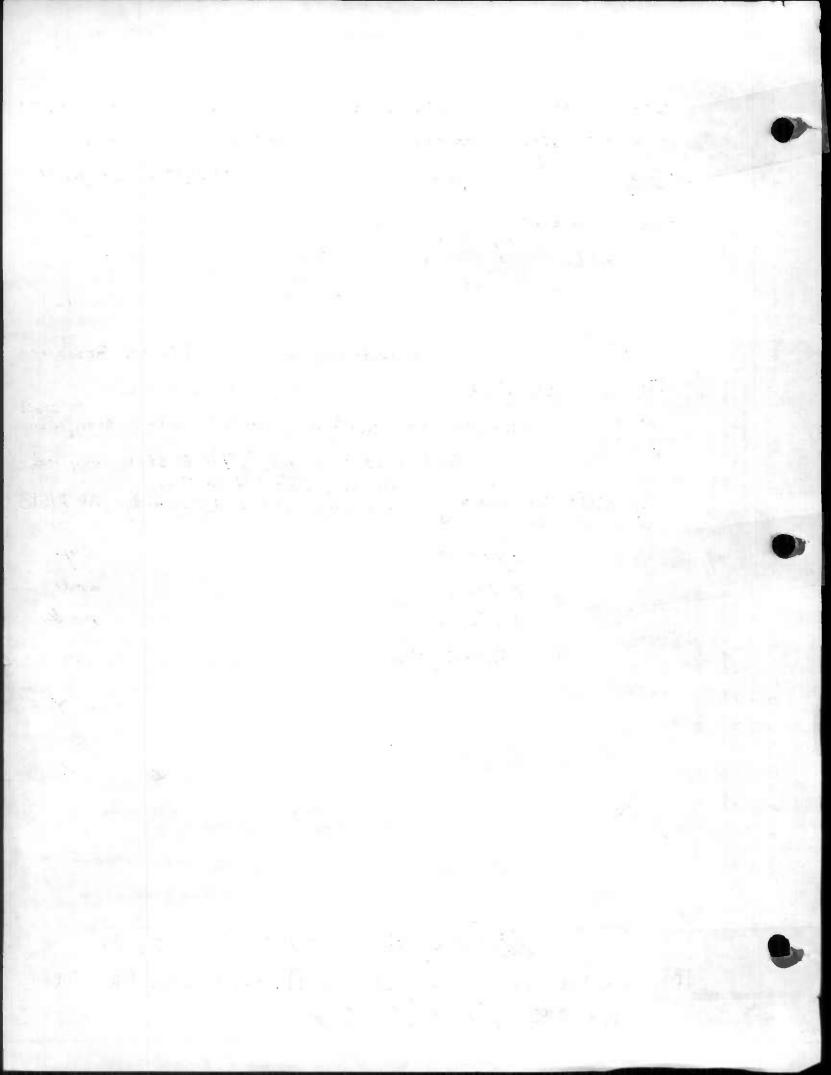
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Physician	1. Decedent's Name (First, Middle, La	ist)	Certifica	te of Death	2. Date of Dea	th	3. Time of D
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/Medical Examiner	4e Facility Neme (If not institution, giv		20100		r Location of Deeth	1	
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Funeral		Sax 7. Age (In yrs. k	Months	or 1 Year If Under 24 H		, Year)	Birthplace (State or F Country)
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notifie recto	10e. Street and Number	Route -1		ip Code		10g. Citizen of W	/hat Country?
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or items 23s or 28s-f sho miner must be notified at Funeral Director	11. Maritel Status	12. Was Decedent Ever in U,S Armed Forces?		edent of Hispanic Origin? ecify Cuban, Mexicen, Pu	(Specify Yes or No-	14. Race Biack	- Americen Indian, k, White, etc.
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MERCAN d by	3 Widowed 4 □ Divorced	Year or Dates:				40h Kind of Du	10.
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ant: I	4 □ Donation 5 □ Othar (Specif	5+1	Stevens	Cenetery	2/11/99	Easton	v, Makylan
Department mportant: any injury o	21. Signature of Funeral Service Licer	nsee	22. Name a	and Address of Facility	1 1/0440	01	/
6520	Janelle	C. Henry	5101	vashingtor	v St. Ca	MbRi de	ac MD. 210
97/87	23a. Pen J. Inter the disease, or com short or heart tailure. List only	plications that caused the other one cause on each line.	Do not enter the mo	de of dying, such as cerd	iac or respiratory ar	rest,	Approximate Interval Between
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Month Tebruary **Physician** 1:20 p.m ee 1999 haunce /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 6. Sex 1 M 2□ F If Under 24 Hrs. Hours Min. If Under 1 Year 8. Date of Birth (Month, Day, Year) 12 - 3 - 3 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 214-32-549 Months Days 63 Yrs. Director Usuel Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. inside City Limits 27 is marked other than "naturel", or items 23e or 28e-f show traumetic event, the Modical Examinat mant be not the all 1 Yes 2 □ No Directo ocomoke 10f. Zip Code 10g. Citizen of What Country? 8 5 tree-Funeral 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Raca - American Indien 11. Maritel Status Bleck, White, etc. pemit. Pages 1 and 2 should be filed within 72 hours after Department of Heelth and Mental Hygiena. Important: If itam 27 is marked other than "naturel", or iten any injury or other traumetic event, the Medical Examinat 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Black Saltimore, Maryland 21215-0020 1☐ Yes 2MNo Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Supervisor Vater arade 17. Father's Name (first, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Susie Dought Harmon Theodore 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pocomoka City Ce 518 Laure | S
20b. Placa of Disposition (Name of cametery, crematory or other place) Street Dought GENEVIVE -WItc 20c. Location -20e. Method of Disposition Dete 1 Burial 2 Cremetion 3 Removal from State 2-12-99 Pocomoke Md. 21851 Cemetary 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarelice License Bennic Smith Funeral Home 22. Name end Address of Facility P.O. Box 331-Pocomoke 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardlac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Physician Immediata Cause (Final disease or condition rasulting in daath) /Medical Examiner Due to (or as a consequence of): Examiner nerten soon sician end e burial-transit Sequentially list conditions, if any, leading to immediate causa. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): ettanding physician Physician/Medicai Due to (or as e consequenca of): 88 980 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. the 1 Ves 2 No 3 Probably 4 Unknown signed by py Division of Vital Records. 99 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Deeth (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dinpatient Certification: To 2 ER/Outpetient 3 DOA Aftar this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 ☐ Yas 2 ☐ No 2 Accident aftar deeth Director: 6 Could not be datamined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 5 To the Hospital o within 24 hours af To the Funeral D completaly filled i 29a. Certifier 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end dua to the cause(s) and menner as stated. Medical 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) end menner stated. (Check only one) 290. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 00054127

Registra

State

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

A. DA VIS
31. Dete filed (Month, Day, Year)

FEB 1 1 1999

3 13; 5km

32. Régistrar's Signature

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Drain Joseph C. 1010 9 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Balt: more R Adams Cowley Shock Trouma Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 02-22-1925 BALTIMORE 6. Sex 1 ☑ M 2 ☐ F 9. Birthplace (State or Foreign Country)
LEWES, DELAWARE 5. Social Security Number 222-22-8434 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No DELAWARE SUSSEX **MILLSBORO** 10a. Street and Number 10g. Citizen of What Country? 10f. Zip Code RD#8 BOX 55 19966 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yas 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) FARMING 10 SELF EMPLOYED FARMER 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) CLARENCE DRAIN LOUISE MAZE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY I. DRAIN RD#8 BOX 55, MILLSBORO, DE. 19966 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burlai 2 XCremation 3 ☐ Removal from Stata MELSON'S CAPE HENLOPEN 4 ☐ Donation 5 ☐ Other (Specify) 02-08-99 FRANKFORD, DE. 21. Signature of Pu 22. Name and Address of Facility MELSON FUNERAL SERVICES LONG NECK RD., MILLSBORO, DE. 19966 23a. Part. Entar tha disease shock, or heart feilure. Approximate Interval Between Onset end Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final · Necrotizing Acute Soft Tissue Infection of Abdomen disaase or condition resulting in death) Due to (or as a consequence of): Intra-Abdominal Sequentially list conditions, if any, leading to immadiata ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 2 1 No 1 ☐ Yas 1 TYes 2 No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

physician and s the burial-transit

this certificate

The law requires that the death certificate be executed

Box 68760

P.O.

Records,

Vital

of

Division

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiena. Important: if item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examina Back.

altimore. Maryland 21215-0020

Examiner Physician/Medical þ Completed Be

Certification: To

bengis Hospital or Attending Physician: 24 hours after death. Euneral Director: After this certificately filled in by the funeral director, g

edical

27. Menne of Death 1 Natural 2 Accident

29a, Certifier

3 Suicide 4 ☐ Homicide

5 Pending investigation 6 Could not be determined

29b. Signature and title of certifier William (

28a. Dete of Injury (Month, Day Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

046147

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated. 29c. License number 29d. Data signed (Month, Dav. Year) Chin no

William C. Chiu, N.O 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

William C. Chiu, n.O. R Adams Cowley Shock Trauma Center Bultimore, MD 21201 31. Date filed (Month, Pay, Year)

State Registrar 32. Registrar's Signature

To the Hospital o within 24 hours aff To the Funeral Di completely filled in

parker to the grade of the con-

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible 5 0 0 4

State of Maryland / Department of Health and Mental Hygiene

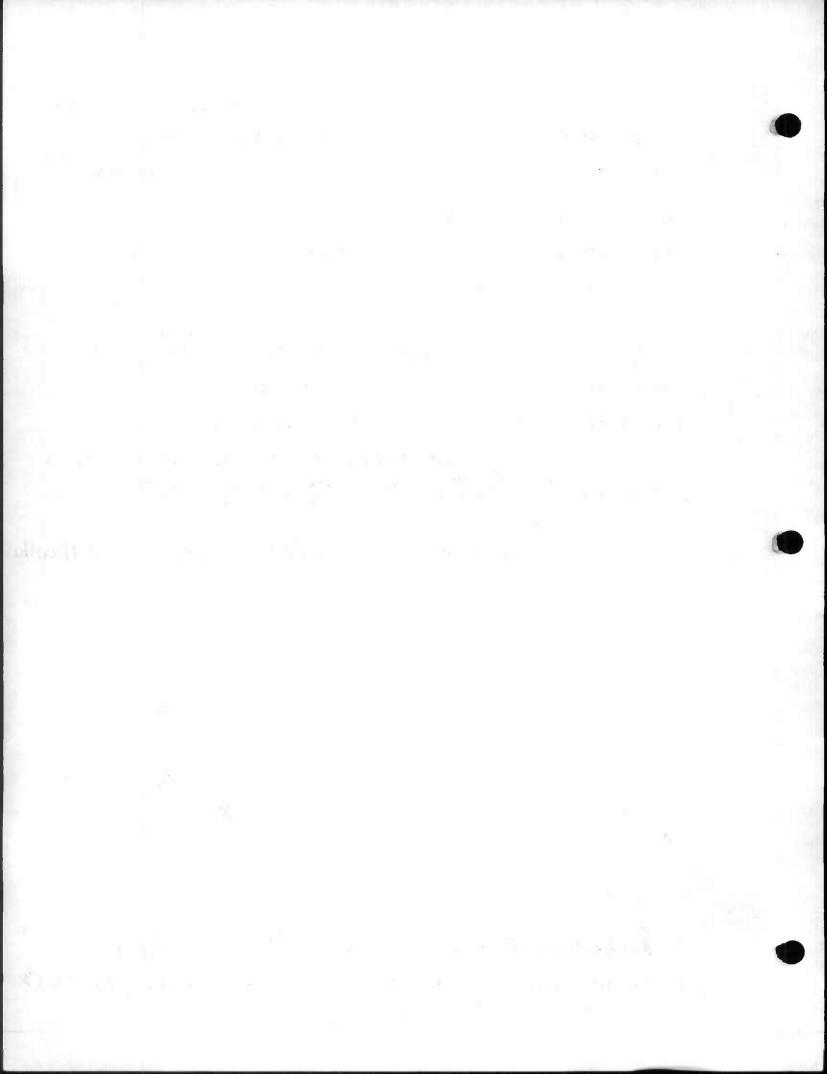
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** FEBRUARY 2, 1999 JOHN HENRY DUFF 7:15AM /Medical 4a. Fecility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1708 RACE STREET CAMBRIDGE DORCHESTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Sociel Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Vrs 70 Director 308-28-3518 SEPT. 16, 1928 KENTUCKY Usual Residence of Decedent 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 XYes 2 No Director MARYLAND DORCHESTER CAMBRIDGE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1708 RACE STREET 21613 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian, Black, White, etc. Baltimore, Maryland 21215-0020 1 Never Married 2 M Married 1 ☐ Yes 2 XNo Specify: p Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. STATE Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w Department of Heath and Mental Hygien Important: If them 27 is marked other th any Injury or other traumatic awant the HEAVY EOUIPMENT OPERATOR HIGHWAY ADMINISTRATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 WILLIAM DUFF ERSIE MOSLEY 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EVELYN HELTON DUFF/WIFE 1708 RACE STREET, CAMBRIDGE, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removel from State 4 Donetion EAST NEW MARKET CEMETERY 2/4/99 EAST NEW MARKET, MD 5 Other (Specify) 21. Signature of Foneral Service Lice ZELLER FUNERAL HOME, P. O. BOX 207 106 MAIN STREET, EAST NEW MARKET, MD 21631 Page. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, which, or heart tailure. List only one each line. Physician Metaitatic Gall bladder Cancer /Medical Immediate Cause (Final Month disease or condition resulting in death) Examiner Examiner physicien and the buriel-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of) Box 68760. Physician/Medicai Due to (or as a consequence of): resulting in death) Last ası ettending p for use as Division of Vital Records, P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the 2 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were eutopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? peen page 2 has 2.0 No certificata 1 Tyes 1 ☐ Yes 2 No al or Attending Physician: T s after death. It Director: Atter this certificat od in by the funaral director, p Be 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 ☐ Nursing Home

¶ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital or A within 24 hours after To the Funeral Director Complataly filled in by 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and manner as stated.

| Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai (Check only onel 29b. Signetyre end title/of certitier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) X. Cambridge, MD 21613 19 Willram tranklin 31. Date tiled (Month, Day, Year) 32. Registrar's Signature State FEB 4 1999 Registrar

DHMH 16 Rev 6/95



Amended line 19a. 2-10-99 SC

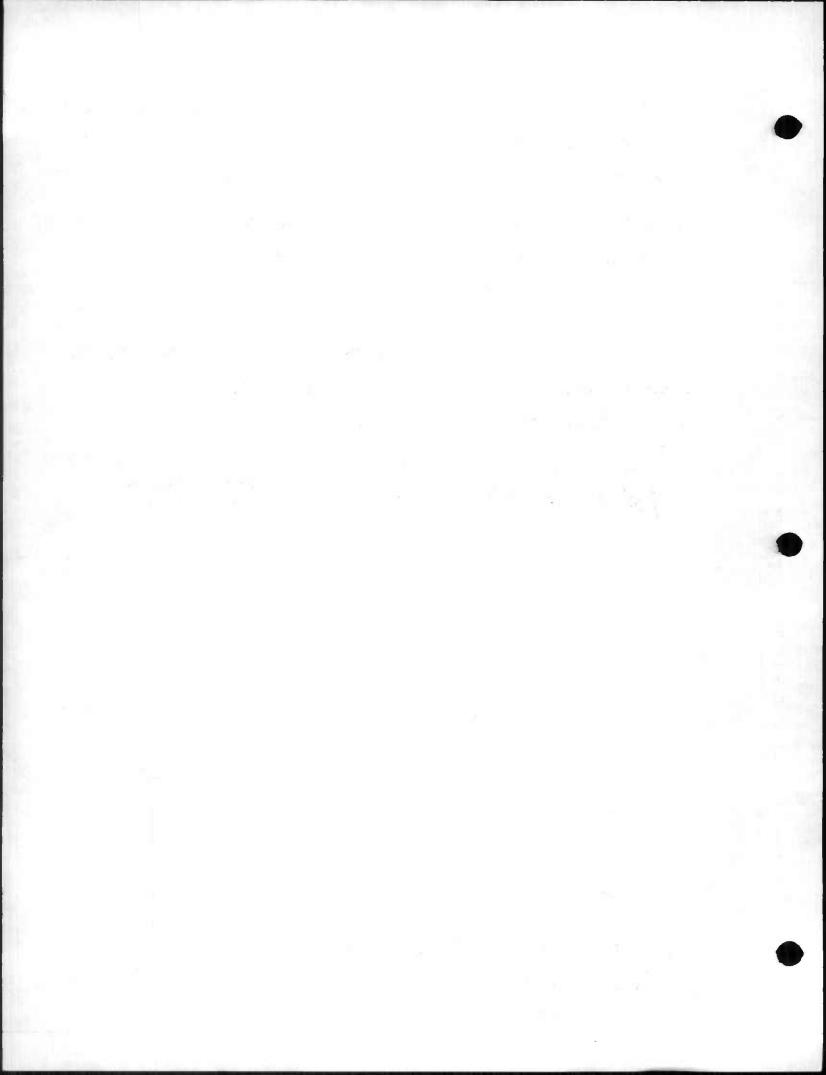
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State of Maryland / Department of Health and Mental Hygiene

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	sician edical	JOSEPH FRANKI	LIN EAKLE JR				FEBRUARY	5 1	Year 999	6:15 P.M.
C	miner	4a. Facility Nama (If not institution, given	ra street and numbar)			4b. City, Town, or L	ocation of Daath	4c. County	of Death	view
		110 ORCHARD DRI					SBORO		SHIN	
Funei Direct	_	5. Social Security Number 6. S 218-30-9335 Usual Rasidence of Decedent	Sax 7. Aga (In yrs	. last birthday) Yrs.	If Undar 1 Year Months Days		8. Data of Birth (Month, Day, 1)	1927	9. Birthpl County	laca (Stata or Foreign try) IARYLAND
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To the comp	Me	29b. Signatura end title of certifiar	110		29c. Licans	se number	290	d. Date signed	(Month, L	Day, Year)
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DHMH 16 Rev 6/95



Please Type or Print in Black Indeible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death EZEV James Gebruary 4b. City, Town, or Location of Deeth 4a. Facility Nama (if not institution, giva street and number) 4c. County of Deeth Dorchester General Hospital Cambridge Dorchester 8. Data of Birth (Month, Dey, Year) If Under 24 Hrs. Hours Min. 9. Birthpiece (Stete or Foreign 1933 Maryland 5. Social Sacurity Number €M 2□ F 220-28-1828 66 Usual Residence of Decedent 10h Count 10c. City, Town or Location 10d. fnslda City Limits Dorchester Hurlock VOYOS 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 206 Glen Oak Circle 21643 U.S.A. 12. Was Dacadant Evar in U,S. Armed Forces? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Ricen, atc.) 14. Race - Amarican Indien, Bieck, White, etc. 11. Marital Stetus 1 Navar Married 2 Married 1 ☐ Yas 2 ☐ No If Yes, Give Yaar or Datas: 1 Yes 2 No white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working iife. DO NOT usa retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) welder wire belt mfg. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumema) Milton Elzev Bessie Burton 19e. Informent's Neme/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Patricia T. Elzey - wife 206 Glen Oak Circle, Hurlock MD 21643 20b. Pleca of Disposition (Name of cematary, cremetory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, Stete Burial 2 Cremation 3 Removel from Steta Dorchester Memorial Park 2-4-99 □ Donetion 5 □ Other (Specify) Cambridge Maryland 22. Neme end Address of Facility Thomas $\mbox{ Funeral Home PA}$ 21. Signature of Funerei Service Licensee 700 Locust St. Cambridge, MD 21613 23a. Pert / Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heef feilure. List only one cause on each line. Approximate Interval Between Onsat and Death fmmediata Causa (Final diseese or condition resulting in deeth) Sederal years

Physician /Medical Examiner

Physician

/Medical

Examiner

10a Stata

MD

Director

Funeral

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Completed

Funeral

Director

72 hours after death with the Meryland

permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryla Department of Health and Mental Hysiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Exercities must be notified at once.

Baltimore, Maryland 21215-0020

attending physician and for use as the burial-tran been signed by should be detac page 2 s To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; to

Division of Vital Records, P.O. Box 68760,

Physician/Medical þ Completed Be 2 Medical

Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted avents resulting in deeth) Last 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown TAChy CARDIA

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Periferal Vascular -over Extremity

24a. Wes an eutopsy performed?

24b. Were autopsy tindings aveileble prior to completion of causa of death?

SKING

25. Wes case referred to medical exeminer? 28. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatient 2 Proutpatient 3 DOA 28d. Describe how Injury occurred

28e. Dete of injury (Month, Dey Year) 27. Manner of Deeth 5 Pending investigation 2 Accident 3 ☐ Sulcide 6 Could not be

28b. Time of Injury 28c. Injury at Work? 1 Yes 28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28t. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier

4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner as steted.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete and plece, end due to the cause(s) end manner stated. 29c. License number

29b. Signeture end title of cuftitier

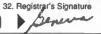
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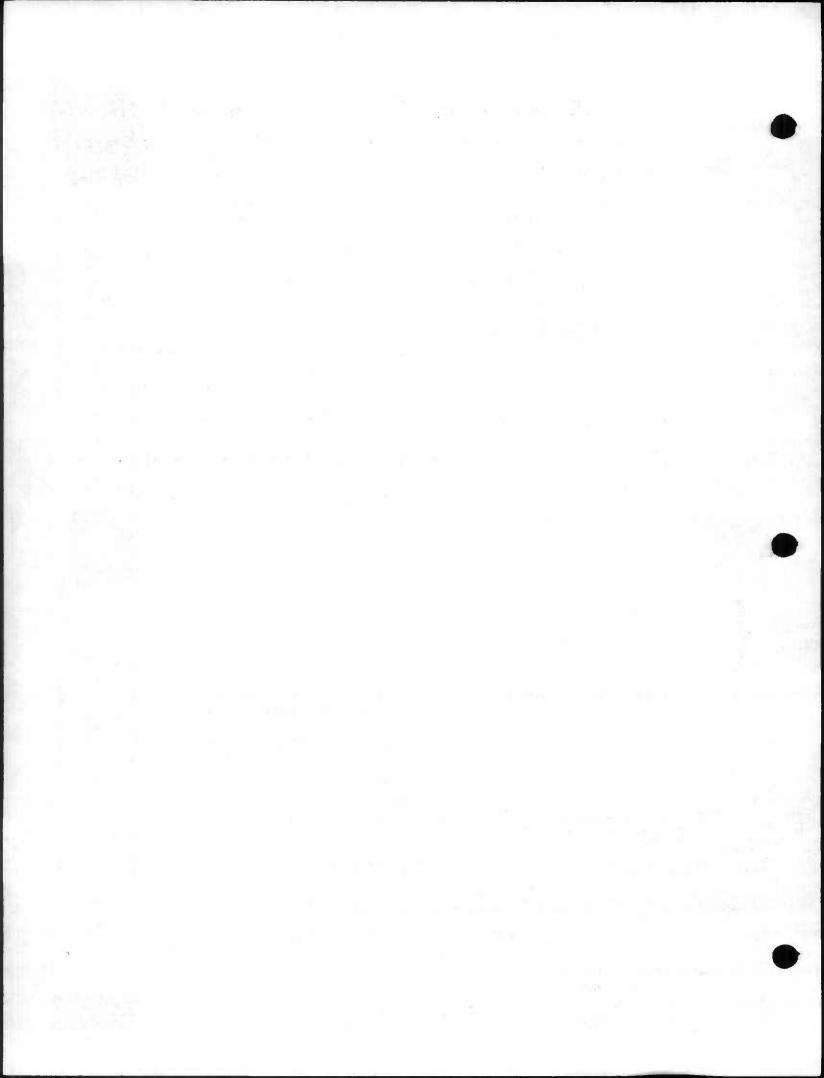
29d. Dete signed (Month, Day, Year) Feb. 3, 1999

30. Name and address of person who complated dause of death (item 23e) (Type, Print)

Cambridge MD 21613 Lois Narr, D.O. 2 Aurora St. 31. Date filad (Month, Dey, Year)

State Registrar





		EMS: #23 PART 1. Decedent's Name (F			G/68 2	-24-990	Sertifica	ate of	Death		2. Date of D	Reg. No.		3. Time of Death
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Funera Directo		5. Social Security Number 226 08 52	Sex 14 M 2 D F					If Under Hours	24 Hrs. Min.	8. Date of B (Month, D	irth Pay, Year) 65		irthplace (State or Foreign Country) HINGTON	
dand ow		Usual Residence of Dec 10a. State 10	b. County		10c.	City, Town	or Location							10d. Inside City Limits
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th with t	al Dir	10e. Street and Number			Zip Code 4558				10g. Citizei	n or wriat C	ountry r			
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Division of Vital Records, P.O.

AM

29c. License number O.C.M.E 29d. Date signed (Month, Day, Year) FEB. 7, 1999

30. Name and eddress g pleted cause of death (item 23a) (Type, Print)

AlT Penn Street, Baltimore, Maryland 21201 2058 31. Date filed (MoAth, Day, Year) 32. Registrar's Signature

State Registrar

FEB 1 6

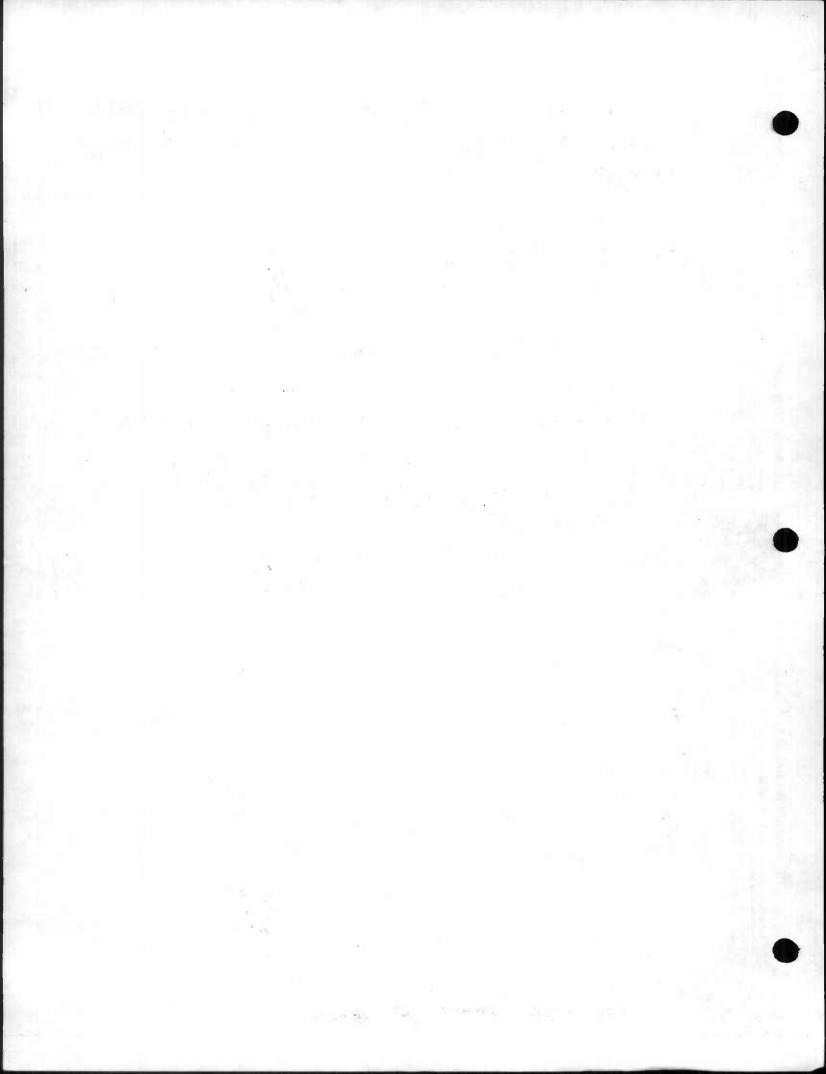


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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 5508

					Certifica	ate of	Death		Reg. No.				
		1. Decedent's Name (First, Middla, I	ast)					2. Date of D	eath		Tima of Death		
Physici /Medic		Paul H		+	ansi	ler		Janua	Day	1999 O	5:47		
Examin		4a Facility Name (If not institution, g	iva street and number		1		4b. City, Town, or	Location of Dea			<u></u>		
		Johns Hopk	cins Ho	spita	1		Balti.	more	Ba	Itim	028		
Funeral		5. Social Security Number 6	Sex 7. A	ge (In yrs. last I	oirthday) If Un Monti	der 1 Year hs Days	If Under 24 Hrs Hours Min		rth av Year)		Stata or Foreign		
Director		234-36-6090 104 73 Yrs. APR 24, 1925 Usual Residence of Decedent									WEST VIRGINIA		
Now Man		10a. State 10b. County		10c. City, To	wn or Location					10d. In	side City Limits		
death with the Maryland me 23e or 28e-f show mat be notified at	Director	WV BERKEL	EY	MARTI	NSBURG					1	Yes 2 No		
5 6 9	S S	10e. Street and Number			10g. Citizen of V	10g. Citizen of What Country?							
23 v		805 LUPTON DRIV	E			25401			USA				
1 21215-0020 led within 72 hours after death viggens. her than "natural", or herre 28 hit the Medical Examiner must Completed by Funeral	p	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes. Give	?	1□ Yes	specify Cubs		Specify Yes or Norto Rican, etc.)	Specify	ee - American Ind ck, White, etc.			
	15. Decedent's (Specify only highest of	Education		a. Decedent's U	sual Occup	ation during most of we	ndrina	16b. Kind of Br	usiness/Industry				
	Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO NO	T use retired	during most or we	Jinny						
	Co				ENGI	NEER				TELEPHO	NE CO.		
Maryland 42 should be Ille th and Mental Hy 7 is marked oths traumatic event	Be	17. Father's Name (First, Middle, La					18. Mother's Ne	ema (First, Middle	, Maiden Suman	10)			
N Market	10	JOHN R. FANSLER						HENSLEY					
Ma d 2 a d f la a d f la a d		19a. Informant's Name/Relationship		15				Rural Route Numl)		
the Tage	-	FRANCES M. FANS 20a. Method of Disposition	LEK/WIFE	20b Place	of Disposition (/		KIVE, MA	RTINSBU		25401 City or Town, S	tata		
Baltimore smit. Pages 1. Appartment of He mportant: If her ny injury or oth diss.		1 ☐ Burial 2 ☐ Cremation 3		cemei	ery, crematory of	or other pled			200. Location	Oily of Town, 3	lata		
Hing and a second		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		PLEAS	ANT VIE		. GAR .	2-2-99	MARTINS	BURG, W	J		
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Examiner		disease or condition resulting in death)	In	traa	bdom	10a	1 Dep	0515		20	Jays		
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ds, P.O. Box lies that the deeth cer signed by the attendin id be detached for use	Physician/N	Pana		arcinoma 10 Yes 200						3 Probably	4 Unknown		
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Affect Fune	to l	1 Natural 5 Pending 2 Accident investigati	(Month, De	y Year)	Injury	28c. Injury	K? Yes 2 No	250. 5030150	now argury occor	.00			
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D Page	Certification:	4 Homicide		ic. (Specify)					wn, Stata)				
Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifier 18 Certifying F	hysician: To the best miner: On the basis of	of my knowledg	ge, death occurr	ed et the tin	ne, data and plac	e, and due to the	cause(s) and ma	anner as stated.	equea(e)		
the H the F the F		ane)	and menner st	ated.				uned at the time					
No To Poo	Σ	29b. Signature and title of certifier	0 ()	0		29c. Licens			29d. Data signe		(ear)		
		Kobert	1dd	rosd,	0,	RES	>-00	0	1-29	7-99			
	1	30. Nama and address of person who	completed cause of	death (Item 23a) (Type, Print)		11	1.	11.	1 1			
		KOBRH / 31. Data filed (Month, Day, Year)	prozd	M·D	1	Ohn	SHOP	kins	70Sp17	ra/			
Sta	e	TED 1 C	1000 32. Hegel	rar's Signature	4	han.	1		/				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Ruh Fockles Mildred February 6, 1999 6:30 PM 4c. County of Death 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 6236 Sawyer Road New Market Frederick If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Nov. 22, 1906 Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) Days Hours 10 M 2Q F 217-18-7447 Yrs 92 **Usual Residence of Decedent** 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick New Market 1 ☐ Yas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6236 Sawyer Road 21774 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3₺ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail Bookkeeper 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Minnie May Liddington Edward Daniel Duke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Townsend/grandson 6236 Sawyer Road, New Market, Maryland 21774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee e State Anatomy Board, 655 W. Baltimore Street Di/rector Baltimore, Maryland 21201 art1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failura. List only one cause on each line. Approximata Intarval Batween Onset and Death Immediata Causa (Final Respiratory failure due to disease or condition rasulting in death) 3 Jeans Due to (or as a consequence of): COPO Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) May Prouse with Seven Brodycanlin Adrial RibNeto 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 25€No 24b. Ware autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yas 2 ☐ No 26. Place of Death (Check only one)

Physician /Medical Examiner

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After

To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun.

Physician

/Medical

Examiner

Funeral

Director

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r than "natural", or items 23a or 28a-f ahor the Wedical Examiner must be notified at

filed within 72 hours after

I Hygiene.

i. Pages 1 and 2 should be filed vitnent of Health and Mental Hygie tant: If item 27 is marked other to jury or other traumstic avant, in

permit. Page Department of Important: If any injury or

21215-0020

Baltimore, Maryland

Funeral Director

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Completed

B

Physician/Medical Examiner the burial-transit signed t by Completed funeral director, Be

The lew requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records.

Attanding Physician:

Certification: To 1 Yes 2 340 27. Manner of Death 1 Natural 2 Accident

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was casa refarred to medical Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Date of Injury (Month, Day Year)

Other: 4 Nursing Home 5 Stresidence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

3 ☐ Suicide 4 Homicide 29a. Certifie

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.

28c. Injury at Work?

1 Yes 2 No

29b. Signature and titla of certifier

5 Pending invastigation

6 Could not be

29c. License number 0 46248 29d. Data signed (Month, Day, Year) 2/9/99

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

MARTHEN JAM France MO 110 Barghom's LAN Frederick MD 2170,

28b. Tima of

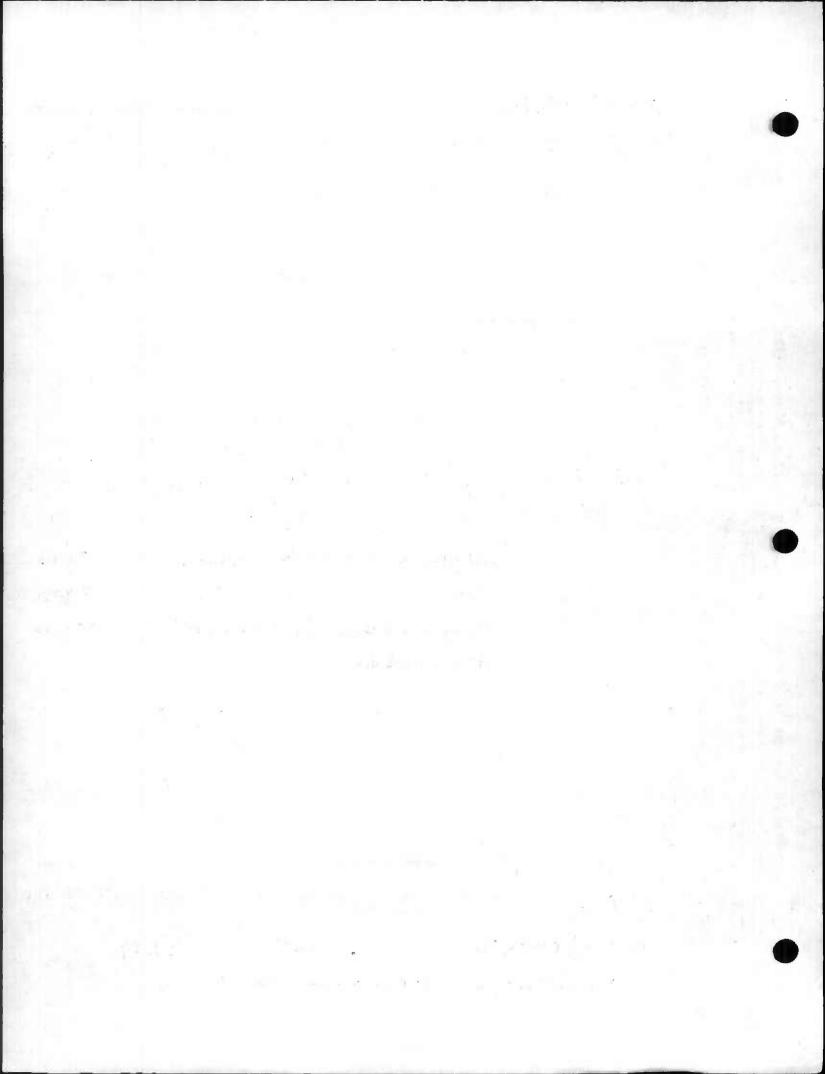
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

Medical

31. Data filed (Month, Day, Year) FEB 1 8 1999

32. Registrar's Signature iperra

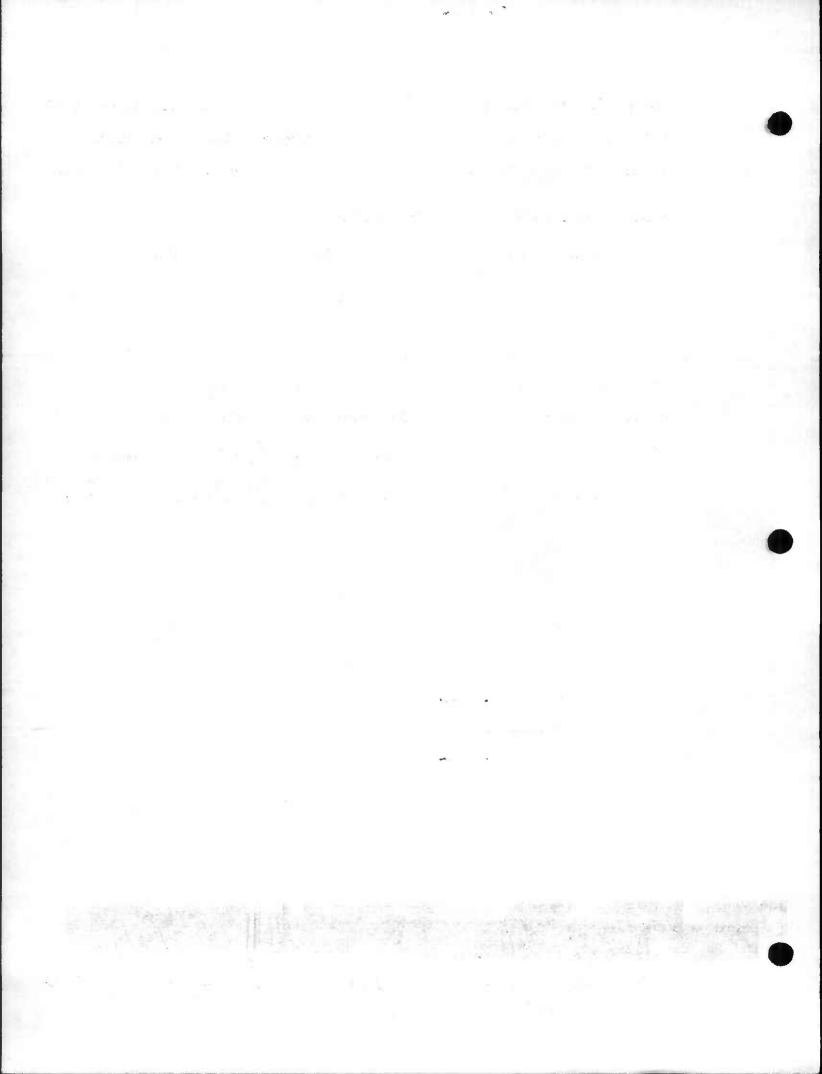


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month Mary Lillian Frederick 1999 Feb. 11:50pm /Medical 4e. Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10522 York Avenue Cockeysville Baltimore If Under 24 Hrs. 8. Dete of Birth (Month Day, Year) Aug. 16, 1907 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year 9. Birthpiece (State or Foreign **Funeral** 1 □ M 2 K F Months Days Maryland 215-32-6047 91 Director Usuei Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location itam 27 is marked other than "natural", or itema 23a or 28a-f show other treumatic svent, the Medical Examinar must be notified at 10d. Inside City Limits Baltimore 1 ☐ Yes 2 No Director Maryland Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10522 York Avenue 21030 USA death v Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. permit. Pagas 1 and 2 should be filed within 72 hours after Department of Haalth and Mantal Hygiena. Important: If Itam 27 is marked other than "naturel", or itel any Injury or other treumatic syent, ma Medical Exempton Black, White, etc. 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: White py Specify: 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 18b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nanny Child Care Provider 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Preston Gardiner Minnie Fair 2 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Robert Frederick 10522 York Ave., Cockeysville, MD 21030 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e, Method of Disposition 20c. Location - City or Town, State Feb 1 XBurlai 2 ☐ Cremation 3 ☐ Removal from Stete 1999 St. Abraham's Cemetery Beckleysville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility J.J. Hartenstein Mortuary, Inc. 21-Signature of Funeral Service Licensee 24 Second Street, New Freedom, PA 17349 used the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, 23s. Part1. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner Ď burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest and Due to (or as a consequence of): physician s the burial Box 68760 Physician/Medical Due to or as e consequence of): usa as attanding P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 90 been si 24b. Were autopsy findings eveilable prior to completion of cause of death? Completed 24a. Wes an autopsy Tha law page 2: cartificata has 1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifics completely filled in by the funeral director, I 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 27. Menner of Death 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Certification: 5 Pending investigation 1 Naturai 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be determined 28e. Placa of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide 29a, Certifler 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. Medical 29b. Signal re and title of certifler 29c. License number 29d. Dete signed (Month, Dey, Year) mo 30. Neme and address who completed cause of death (Item 23e) (Type, Print) 1092 MP 1 31. Date filed (Month, FEB 1 32. Registrar's Signature State 1999 Registrar

DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** MAYBELLE ELIZABETH GIBBONS February 6, 1999 12:10 AM /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner Lexington Park
| | Hunder 1 Year | | Hunder 24 Hrs. | 8. Date of E Bayside Care Center St. Mary's 8. Date of Birth 9. Birthplace (State of Month, Day, Yaar)
June 12, 1916 Westville, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** Min 1□ M 2■ F Months Days Hours Director 82 312-16-7506 Usual Residence of Decedent with the Maryland 10a State 10d. Inside City Limits 10b. County 10c. City. Town or Location "natural", or items 23a or 28a-f show 1 ☐ Yes 2 ■ No Director Maryland St. Mary's 45680 Roper Road, Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20653 United States 45680 Roper Road Funeral Pages 1 and 2 should be filed within 72 hours efter death a net of Health and Mental Hygiene.
This: If term 27 is marked other than "natural", or froms 23 mit; If term 2 traumatic event, in the ore traumatic event, in the 12. Was Decedent Ever In U,S. Armed Forces? 1 ■ Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian 11. Maritel Status Black, White, etc. 1 ■ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1944-1948 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ■ No Specify p 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Civil Service 4 Supervisor 17. Father's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumama) Be Edith Blanche Sawtell George Washington Gibbons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Samuel W. Wolford Nephew 1449 N. Tremont Road, Chesterton, IN 46304 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetery, crematory or other plece) 20c. Location - City or Town, State 1 ☐ Burial 2 ■ Cremetion 3 ☐ Removal from State permit. Page Depertment of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 2/6/99 Alexandria, VA Metropolitan Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 Royald L. Thompsop M01154 22955 Hollywood Road, Leonar 23a. Part. Enter the disease, or complications that ordered the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only or cause the mode of dying, such es cardiac or respiretory errest, Approximate Intervel Between Onset and Deeth **Physician** days /Medical Immediate Ceuse (Final toeumonio disease or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner moule fo thet the death certificete be executed physician and the buriel-trensil Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, Demeu Physician/Medical Due to (or as a consequence of): attending pl signed by the a d be deteched f Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown þ 24b. Were eutopsy findings available prior to 24a. Was en autopsy performed? Completed completion of cause of death? s certificate hes t director, page 2 s 2 N No 1 Yes 2 No Physician: director, 25. Was case referred to medical Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Menner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending Pl 24 hours effer deeth.
 Funeral Director: After th Certification: 5 Pending investigation 1 Netural 1 ☐ Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) end manner es steted.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. To the Hospi within 24 hou To the Fune completely fil 29a. Certifier edical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Shah MD 47066 2-6-

Leonardtown, Maryland 20650

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

8 1999

32. Registrar's Signature

Avani Shah, M.D.

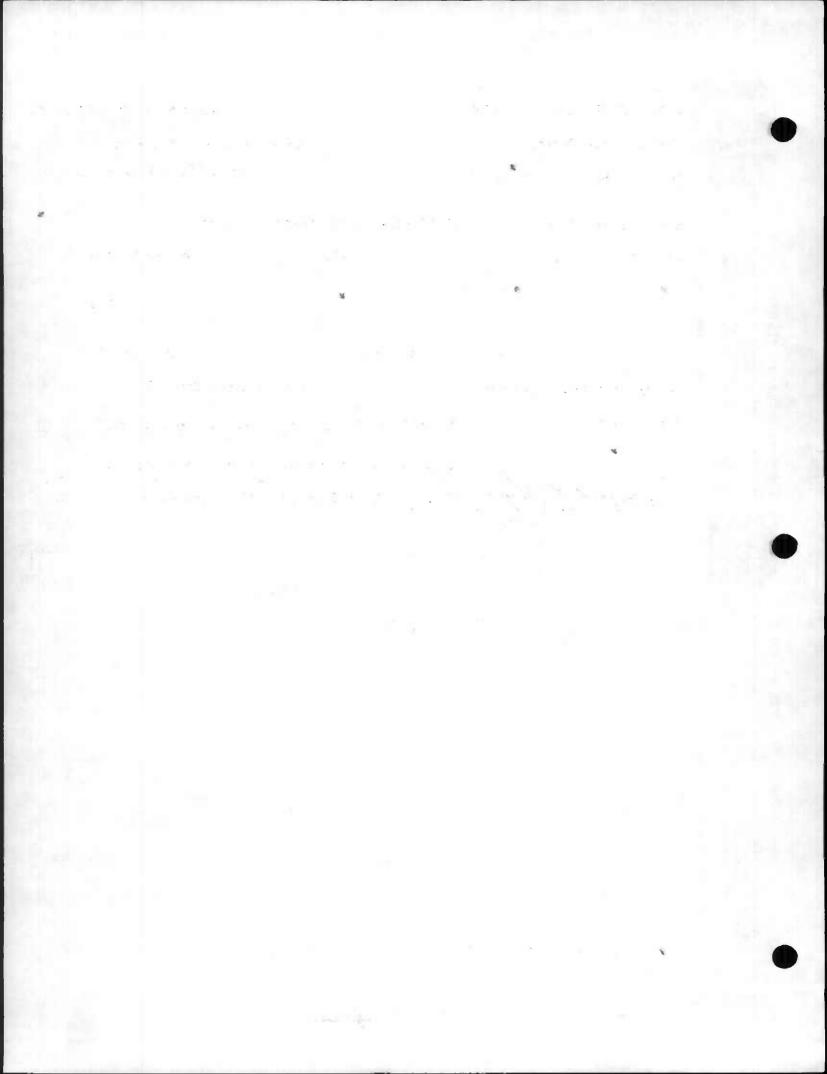
FEB

31. Date filed (Month, Day, Yaar)

State

Registra

DB



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 5 0 1 2

					Ce	rtificat	e of	Death		В	leg. No.		
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Physicia /Medic		MELVA MYLE	TA GUYE	R						Februar	4 B, 1	999	5:35 PM
Examin		4e. Fecility Name (If not institution,	give street end number	r)				4b. City, To	wn, or Lo	cation of Death		ty of Deeth	
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uneral			3. Sax 7. A	iga (In yrs. les		If Undar	1 Year	If Undar	24 Hrs.	9 Date of Birth			
irector		213-16-0214	1□M 2□xF	95	Yrs.	Months	Deys	Hours	Min.	May 11,	1903	Ma	place (State or Foreign intry) Land
		Usuel Residenca of Decedent											
r 28a-f show notified at	b.	10a. State 10b. County		10c. City,	Town or Lo	ocation							10d. Inside City Limits
Sa-T.	cto	Maryland Wash:	ington	Wi	llia	mspo	rt						1 X Yes 2 □ No
or 21	Director	10e. Street end Number				10f. Zip	Code			1	0g. Citizen of	Whet Cou	intry?
23a		154 North Art	tizan Str	eet		2	179	5			U.S.	Α.	
SE DE	Funeral	11. Marital Status	12. Was Decedan Armad Forces	t Ever in U,S.	13.	Was Deced	dent of H	lispanic Orl	gln? (Spe	ecify Yas or No- Rican, atc.)			can Indian,
or the		1 ☐ Naver Merried 2 ☐ Married							i, Puarto	Hican, atc.)		ack, White	, etc.
2	by	3 ☐ Widowed 4 🎇 Divorcad	Yeer or Datas:	:		1□Yes :	SK1 NO	Specify:			Speci	[™] Whi	ite
netural',	Completed	15. Decadent's (Specify only highest)			16e. Dece	dent's Usue kind of wor	Occup	ation	A = 6		16b. Kind ot E	Business/Ir	ndustry
Z N	ğ	Elementary/Secondary (0-12)	College (1-4or	5+)	lile.	DO NOT us	se retired	d) mos	E OF MOUNT	ng	Hager	stov	vn
4	S	12			Se	cret	ary				Polic	e De	ept.
vent, th	Be (17. Fether's Nema (First, Middla, La	st)					18. Mothe	r's Nama	(First, Middle, I	Maidan Suma	me)	
gi	10	David Fi	rank Mi	ller				Al	ma	Leona	Ge Ge	arha	art
other traumatic event,		19a. Intormant's Name/Reletionship	(Type, Print)		19b. Mailir	ng Address	(Street	end Numbe	er or Rure	I Route Number	City or Town	, State, Zi	o Code)
127 97 tr		Donald L. Gu	yer	2	12028	Green	ndal	e Dri	ve,	Hagerst	own, Mo	d. 21	742
Important: If Item 27 I any injury or other tra		20a. Method of Disposition			oa of Dispo	sition (Nam	ne of	(a)		Dete	20c. Location	- City or T	own, Stete
ry or		1 X Burial 2 ☐ Cremation 3 4 ☐ Donetion 5 ☐ Other (Spe	☐Removel from Stete cify)	Res	t Ha	ven	Cem	eter	y 02	-11-99	Hagers	town,	Maryland
any injury		21. Signature of Funeral Service Lic			22	2. Name en	d Addres	ss of Facilit	V -			-	
Importar any injur once.		to noch	Brady		A	ndrew	Κ.	Coffin	nan F	uneral	Home,	Inc.	M-I 04740
		23a Port1 Enter the disease or or	mplications that sauce	of the death							-	own,	Md. 21740
		23a. Pert1. Enter the disease, or co shock, or heert failure. List on	ly one ceusa on each I	line.	Do not ent	er the mode	e or ayın	g, such es	cardiac o	r respiretory arri	est,	İ	Approximete Intervel Between
ician dical		Immediete Cause (Final										1	Onset end Deeth
niner		diseese or condition resulting In death)	a ASPIRA	40TI	PNE	OMO	MIA					-	DAYS
	7			Due to (or e		juence of):						1	
ısit	듣		. DYSPI	HAGI	A							1	3 WEEKS
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8 8	Š		d HYPE	RTEN	1510	L							
for u	Fa											1	
detached for u	Physician	Part II. Other significant conditions	contributing to death b	out not rasultin	ng In tha ur	nderlying ca	ausa give	en in Part I.		23b. Dld to	bacco use co	entribute t	o the cause of death?
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should	Completed									24e. Wes er		24b. W	ere eutopsy findings vailable prior to
962	흥									i i i		of	mpletion of cause deeth?
page	0									1 □ Ya	s 2 No	1[□Yas 2□ No
		25. Wes case reterred to medicel		700				26 Plece	of Deeth	(Check only one			
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		27. Menner of Deeth	28e. Dete of inju	Jry 28	b. Time of		Bc. Injury Work			8d. Describe ho			y)
o fun	읉	1 Neturel 5 ☐ Pending 2 ☐ Accident Invastigati	(Month, De	y Year)	Injury	М		(? Yes 2∐1					
d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not	d 286. Pleca of Inj	jury - At home	, ferm, stre	et. tectory.	office		2	8f. Location (Str	reet and Num!	ber or Rure	el Route Number.
S P	e l	4 Homicide	building, ef	c. (Specify)		,				City or Town	, Stete)		
fille		29e. Certifier 12 Certifying P	hyeiclan: To the best	of my knowle	dae deeth	occurred e	t the tim	e dete end	I nlece e	nd due to the ce	useo(s) and m	anner ac e	loted
etah	edical	(Check only 2 ☐ Medical Exa	miner: On the besis of end menner st	f exeminetion	end/or Inv	estigation,	in my op	Inlon, deet	h occurre	d et the time, de	ete end pleca,	and due to	the cause(s)
completaly filled in b	-	29b. Signature end title of certifier				29c	License	number		20	d. Data signe	d (Month	Day Year)
Ö		Como	STACE DULL	SICIA.)								
	-	81,000	STAFF PHY				76	246	2		TO KUN	بسر ک	3, 1999
		30. Name and address of parson who	completed cause of d	feeth (Item 23	le) (Typa, F	Print)	-						
	(GRACE BROOKE HUP 31. Dete filed (Month, Dev. Year)	mm, HD I	8100 5	SCIAL	Scho	or K	DAD S	DAYD	y SPRIN	X, MA	PHLA	09807 da
State				er's Signeture	4	/	pork	1.		•			
Registra	r	FEB 1 0	1999	, -	1.	Jap	out	2					

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PM S parasing specially District Committee of

Budder control of the first of the control of the c

Months

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant'a Nama (First, Middle, Last) 2. Data of Daath 3. Tima of Death Month Day 12:15 am

Physician /Medical **Examiner**

Albert James Gossard 4a. Facility Nama (If not Institution, give streat and numbar)

1999 February 7, 4b. City, Town, or Location of Death 4c. County of Death

Williamsport Nursing Home 6. Sax 1 2 M 2 □ F 5. Social Security Number 7. Aga (In yrs. last birthday)

Williamsport If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Dey, Year)

Washington 8. Data of Birth (Month, Dey, Year) 9. Birthplaca (Stata or Foreign Country)
February 20, 1910 Maryland

Funeral Director

10a. Stata Maryland Director Funeral

þ

Completed

Be

2

Demit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Fundament Process.

214-09-6002 88 Usual Rasidance ot Decedent 10b. County Washington

10c. City, Town or Location Funkstown

Yrs.

10d. Inside City Limits Yas 2 No

10e. Street and Number

109 E. Chestnut St.

21734

10f. Zip Coda

United States

10g. Citizen of What Country?

1 Nevar Married 2 Married 3 XWidowed 4 ☐ Divorced

12. Was Dacedant Evar In U,S. Armed Forças? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas:

 Was Decedant of Hispanic Origin? (Specify Yas or No-lt Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1 ☐ Yas 2 TNo Specify:

14. Race - Amarican Indian, Black, Whita, atc. White Specify:

15. Decedant's Education (Specify only highest grade completed) Elementery/Secondary (0-12)

College (1-4or 5+)

16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Building Contractor

16b. Kind of Businass/Industry Self employed

20c. Location - City or Town, Stata

8 17. Fathar's Nama (First, Middla, Last)

21. Signature of Funeral Service Licenses

David Albert Gossard

18. Mothar's Nama (First, Middle, Meiden Sumama) Lydia Grace Curfman

19a. Informant's Name/Ralationship (Type, Print) Terry Gossard

19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 892, Funkstown, Maryland 21734

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 □ Donation 5 □ Othar (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other place) Rest Haven Cemetery

2+10-99Hagerstown, Maryland

22. Nama and Addrass of Facility Minnich Funeral Home 415 E. Wilson Blvd., Hagerstown, Maryland 21740

Physician /Medical Examiner

or Attending Physician: The law requires that the death certificate be executed

cartificate

After this

after death.

within 24 hours a To the Funeral D completely filled

funaral director,

tha

filled in by

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Completed

Be

2

Certification:

Medical

Box 68760.

Division of Vital Records, P.O.

Examiner signed by the attending physician and do be detached for use as the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical

INFLUENZA

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Dua to (or as a consequence of)

Due to (or as a consequenca of):

Immediata Causa (Final disaasa or condition rasulting in daath)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown

SENILE

DEMENTIA

24b. Wara autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 □ Yas 2 No 1 ☐ Yes 2 ☐ No

Approximata Interval Batween Onsat and Death

3 DAYS

25. Was casa raterred to medical axaminar? 1 Yas 2 No

5 Panding invastigation

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Data of Injury (Month, Day Year) 28b. Tima of

28c. Injury at Work?

1 ☐ Yas 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Dascribe how injury occurred

4 Homicida

27. Mannar of Death

2 Accident

3 Sulcida

6 ☐ Could not be detarmined 28a. Place of Injury - At homa, tarm, streat, factory, office building, atc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Cartifian (Check only one) 12 Certifying Physician: To tha best of my knowladge, death occurred at tha tima, data and place, and dua to tha cause(s) end manner as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, data and place, and dua to the cause(s) end manner stated.

29b. Signatura and title of certifiar

29c. Licanse number

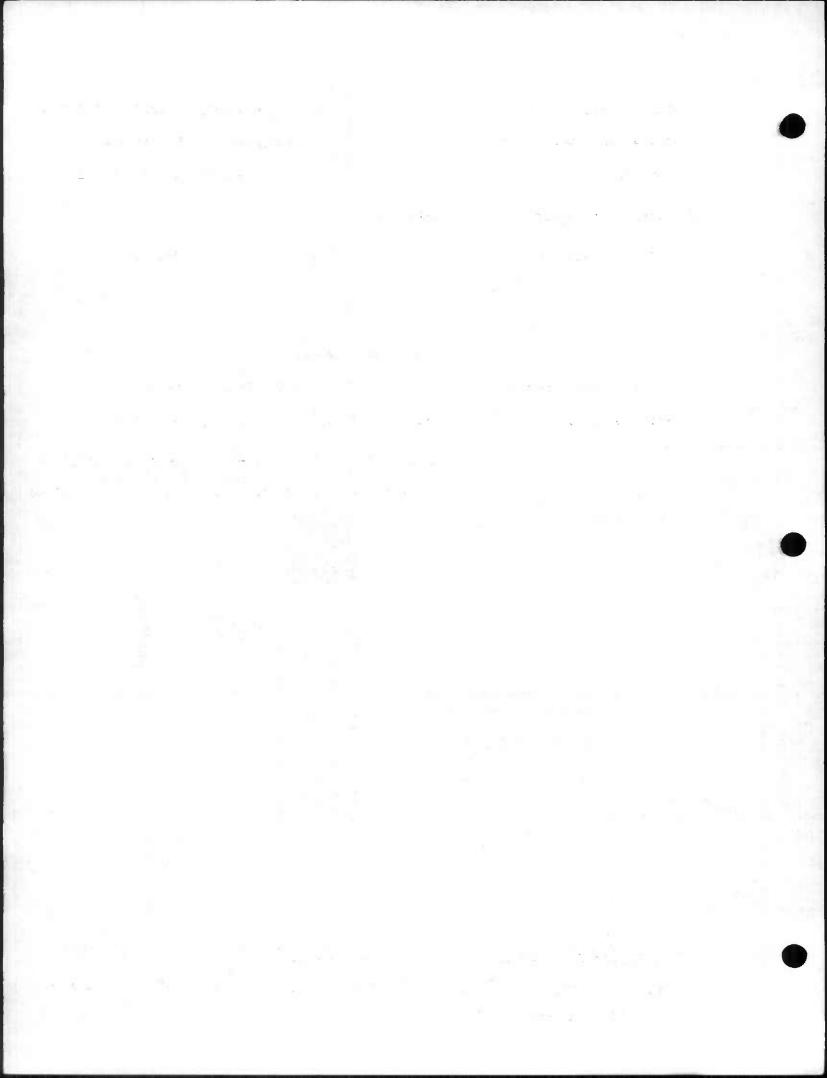
29d. Data signed (Month, Day, Year)

30. Name and eddress of person who completed cause of daath (Item 23a) (Type, Print)

HOWE 31. Data tiled (Month, Day, Year) FEB 0 9 1999

7542 OVERLOOK 32. Registrar's Signatura Deper

State Registrar



Records, P.O. Box 68760 Division of Vital

Examiner Examiner the deeth certificate be executed physician and the bunal-transit Physician/Medical 98 950 signed by the e by Completed page 2 s hes certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific Be To funeral Certification: in by completely filled Medicai

Physician /Medical

Physician

/Medical

Examiner

10a. State

MD.

Directo

Funeral

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Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event. Its Medical Exercises.

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner 1 ☐ Yes 27. Menyer of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Natural 5 Pending 1 Tyes 2 No investigation 2 Accident 6 Could not be detarmined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pleca, and due to the cause(s) and manner stated. (Check only one)

29c. License number

DR

D41721

SALISBURY MD

29d. Date signed (Month, Day, Year)

2/8/99

21804

State Registrar

29b. Signature and title of certifier

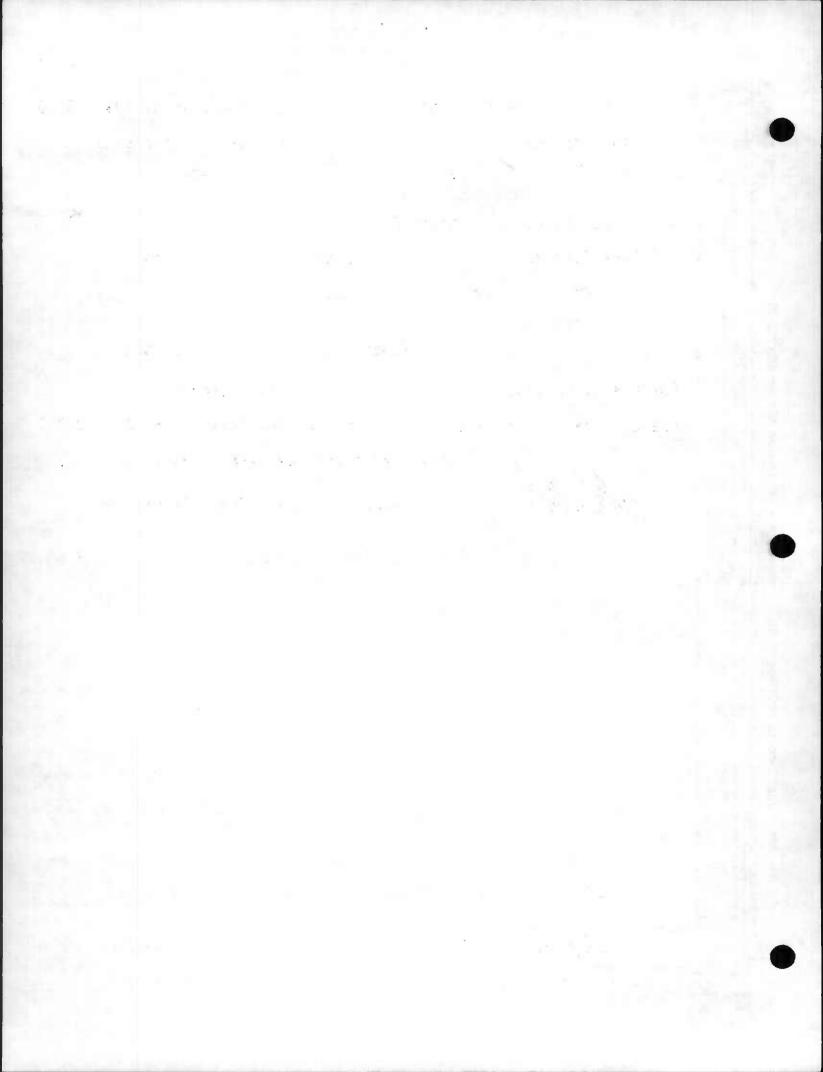
STEPNAN

31. Date filed (Month, Day Year)

400 EASTERN SHORE

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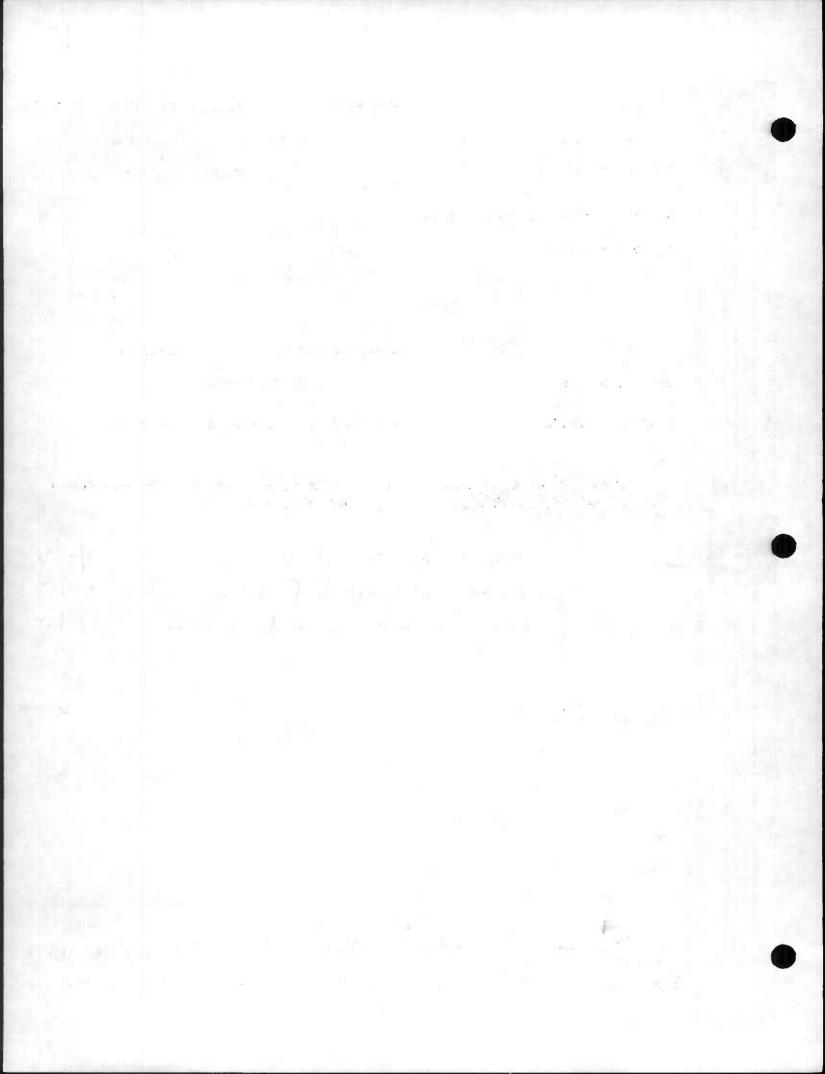
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAVLOS MO



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible 5 0 | 5 State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's Name (First, Middle, Last)					2. Date of De	Reg. No. eth	· · · · · · · · · · · · · · · · · · ·	3. Time of Death						
Physician	R			Ga	506	_	Month	Day	Year	11:30 AM					
/Medical	4e Fecility Neme (If not institution, gi	his street and number		0/4	-	b. City, Town, or I	February		-	11.2					
Examiner			2 6												
				othern and lift Linds	er 1 Year	Baltimo If Under 24 Hrs.			imore						
rector	466-36-5303		e (In yrs. last bii 68	Yrs. Months		Hours Min.	(Month, Da	y, Year) ry 9, 19	9. Birthpia Countr	ace (State or Foreign ny) Exas					
3	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location			10d. inside City Limits								
aho dan		Georges	Bowie				1 ☐ Yes 2 €								
octo		Georges	DOWLE												
el', or items 23e or 28e-f show Examiner must be netified at by Funeral Director	10e. Street and Number 12102 Flint Lan	e			20715			U.S.A.							
ner ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U,S.	13. Wes Dece	edent of Hi	spanic Origin? (S n, Mexican, Puert	pecify Yes or No	- 14. Rac	e - America ck, White, e						
Lay or other traumatic avent, its Medical Lay or other traumatic avent Lay or other Lay or other traumatic avent Lay or other Lay or other traumatic avent Lay or other traumatic avent Lay or other Lay or other traumatic avent Lay or other Lay or ot	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	No 1950-60		2 X No		0 (1104.11) 0(01)	Specify	and the second							
	15. Decedent's 6		. Decedent's Us	ual Occupa	ation		16b. Kind of B	usiness/Indu	ustry						
	(Specify only highest given Elementary/Secondary (0-12)	rade completed) College (1-4or !	54)	(Give kind of w life. DO NOT	vork done d use retired	furing most of wor)	king								
	12	0	Safety Engineer					unkno	wn						
	17. Father's Name (First, Middle, Las	t)				18. Mother's Nar	ne (First, Middle,	Maiden Suman	10)						
	John L. Garner				Ritta	Perron									
	19a. Informent's Name/Relationship	(Type, Print)	198	b. Mailing Addres	ss (Street a	and Number or Ru	ıral Route Numb	er, City or Town,	State, Zip (Code)					
	Loan Garner/wif														
	20a. Method of Disposition	_	20b. Place 0	of Disposition (Na	ame of		Date		1and 20715 20c. Location - City or Town, State						
	1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☑ Donation 5 ☐ Other (Spec	ify)		ary, crematory or	r other plac	θ)									
any is	MIRAMI /	1 liele		State Baltin	21. Signature of Furieral Service Licensee Ronald S Wade, Director State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201										
niner		, 0110 00000 011 00011 11	ne.	TIOL BITTEL THE THE	ode of dyin	g, such as cardia	or respiratory e	rrest,	,	Approximete Intervel Between					
dical niner	Immediate Cause (Final disease or condition resulting in death)						c or respiratory e	rrest,	,	approximate intervel Between Onset and Death					
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te of Maryland / Department of Health and	Mental Hygiene	03010.
Certificate of Death	Reg. No.	
	2. Dete of Deeth January 30, 1999eer	3. Time of Deeth 7:13p.m.

Physician /Medical Examiner 1. Decedent's Neme (First, Middle, Last)

the deeth certificate be executed the ettending physicien end thed for use as the buriel-transit deteched signed by thef should peeu hes this certificate Physician: funeral n 24 hours efter deeth.

• Funeral Director: After th
bletely filled in by the funeral or Attending Division

ALICE CHRISTINE HERBERT

NAME:

Christine Herbert Alice 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth St. Mary's Hospital St. Mary's Leonardtown If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Deys Months 1 ☐ M 2 🗓 F 75 December 3, 1923 Maryland Director 214-42-2733 Usuel Residenca of Deceden with the Marylend 10c. City, Town or Location 10e. Stete 10b. County 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Madical Examines must be notified at Maryland St. Mary's Bushwood Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 22394 Chickahominy Road 20618 U.S.A. Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specity Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien 11. Maritel Status Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or heary injury or other traumatic. 1 ☐ Yes 2 📉 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black by 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12th Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Cola Shaw Scriber Hawkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) P.O.Box 65, Bushwood, MD 20618 Alice A. Butler/Daughter 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State Buriel 2 Cremetion 3 Removal from State 2/4/99 Sacred Heart Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) Bushwood, MD 22. Name and Address of Fecility . Mattingley-Gardiner Funeral Home, P.A. 21. Signature of Funeral Service Licens P.O.Box 270, Leonardtown, MD 20650 It ter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, or heart feilure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) Examiner Due to (or es e consequence of) Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events Due to (or es e consequenca of) Box 68760, Due to (or es e consequence of): resulting in death) Lest 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.0. 1 Yes 2 3 Probably 4 Unknown of Vital Records, Completed by 24a. Wes en eutopsy performed? Be 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one)

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Birthplece (State or Foreign Country)

10d. Inside City Limits

Approximete Intervel Between Onset end Deeth

1 ☐ Yes 2 No

State Registrar

completely

within 2

0

10

Certification:

edical

31. Dete filed (Month, Day, Year) 2 1999 FEB

Dr. James C. Boyd

29b. Signeture end title of certifier

1 ☐ Yes 2 No

5 Pending investigation

6 Could not be determined

2 ☐ Medical Examiner: On the basis of exemend manper stated

30. Name and address of person was completed cause of death (Nam 23e) (Type, Print)

27. Manner of Deeth

2 Accident

3 ☐ Sulcide

29a. Certifier

4 ☐ Homicide

(Check only one)

32. Registrer's Signature

Hospitel: 1 Impatient 2 ER/Outpalient 3 DOA

28b. Time of

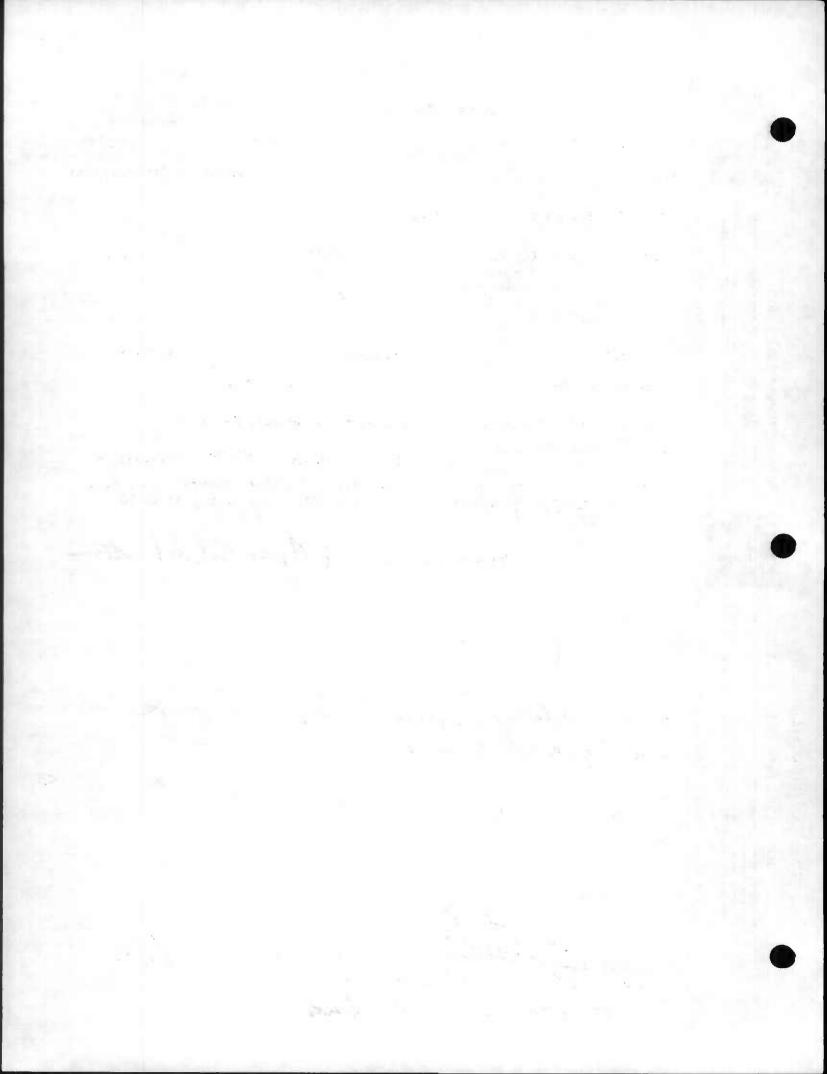
28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

20619 California, Md.

28c. Injury et Work?

29c. License number

1 ☐ Yes 2 ☐ No



The law requires that the death certificate be executed Box 68760. Division of Vital Records, P.O. Attending 0 **Physician**

/Medical

Examiner

Funeral

Director

an "natural", or items 23a or 28a-f show Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after deeth a neat of Health and Mental Hygiene.

Nat: If tem 27 is marked other than "natural", or items 23, mit: If tem treumatic event, it a Menical Evanter muny or other treumatic event, it a Menical Evanter or mun.

Important: If its any injury or oth

Physician

/Medical Examiner

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Director

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24 hours

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Examiner

Physician/Medicai

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Completed

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Certification:

edical

altimore, Maryland 21215-0020

Directo

Funeral

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Completed

Be

with the Maryland

To the Hosp within 24 ho To the Fune completely fi w 10

State Registrar

29b. Signature and title of certifier

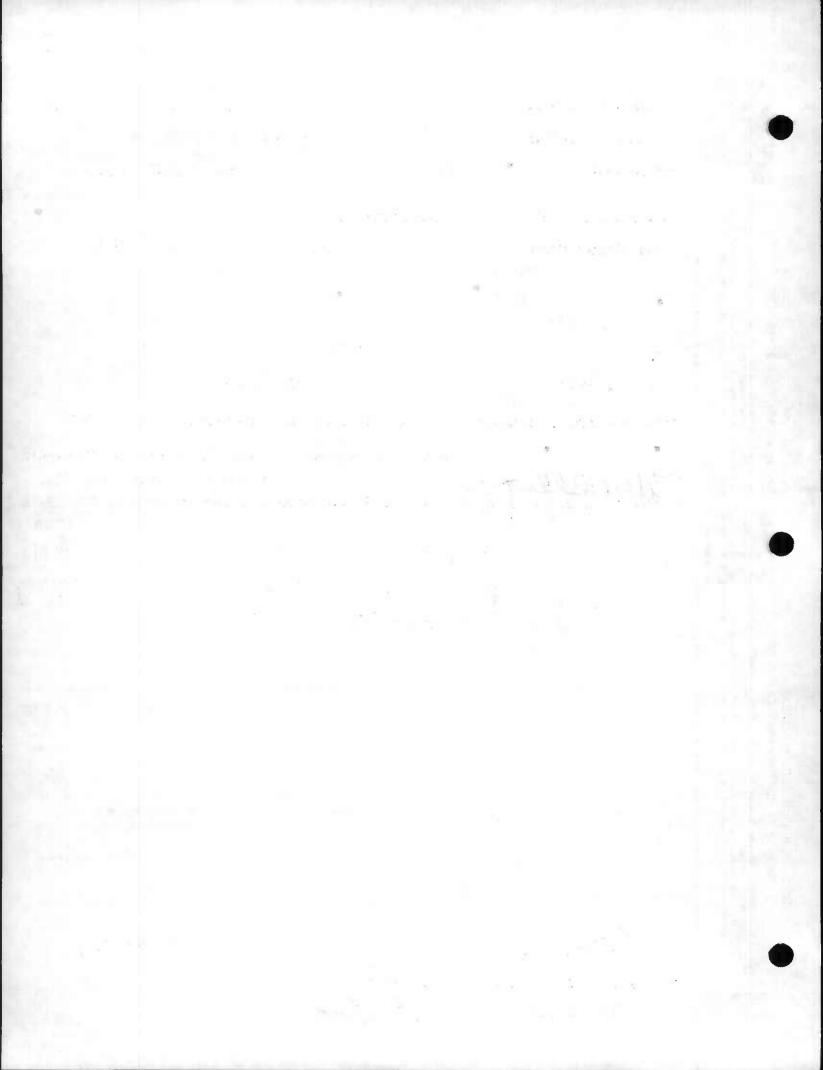
29c. License number 47066 29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

Dr. Avani D. Shah Hollywood, Md.

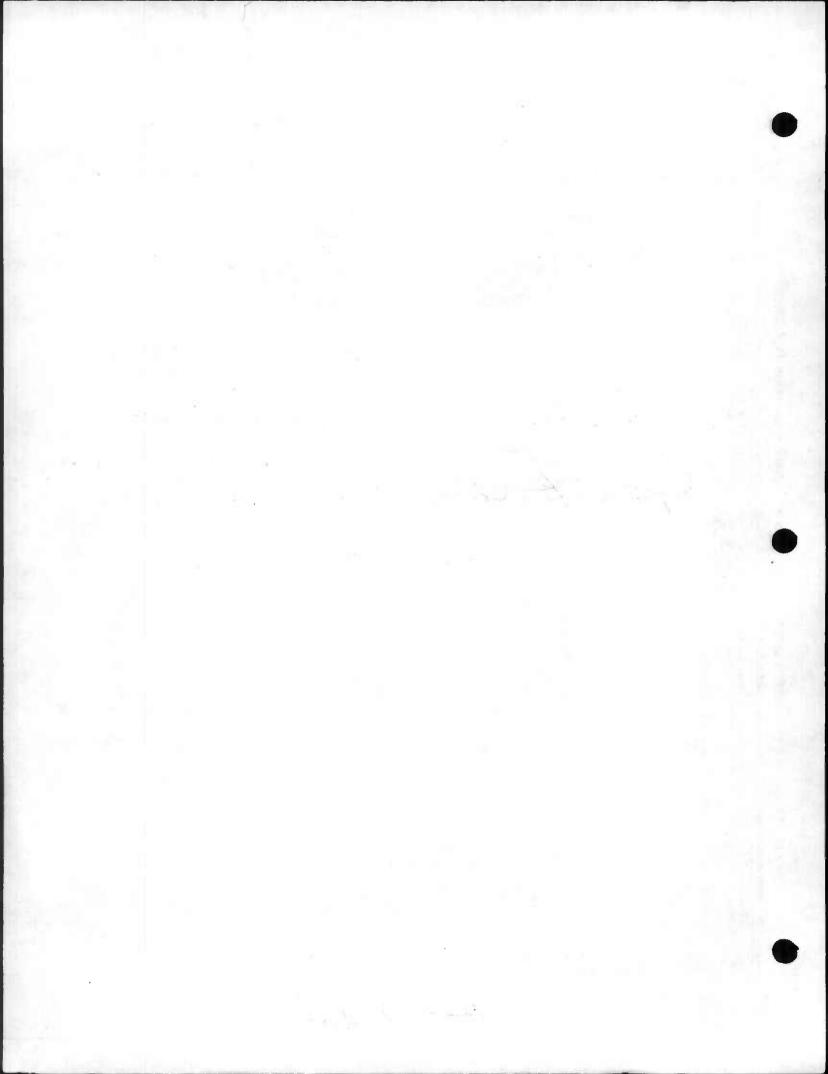
31. Date filed (Month, Day, Year) FEB

32. Registrar's Signeture



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			Otate of Ivie		ertificate of			Reg. No.	05	018		
Physici /Medic		1. Decedent's Name (First, Middla, La Gary Clinton Hu					2. Data of De Month Fennua	Day	ďď	3. Tima of Death (1): 25 AM		
Examin		4a Facility Nama (If not institution, give Washington Cour		l		4b. City, Town, or L Hagerst		,	of Death shingt	on		
Funeral Director		579 - 58 - 0758	Sex 7. Age	(In yrs. last birthde 53 Yrs.	(y) If Under 1 Year Months Days	Hours Min.	8. Date of Birt (Month, Da Aug. 20	th y. Year) , 1945	9. Birthplac	ce (State or Foreign		
ahow stat	J.C	Usual Residence of Decedent 10a. State 10b. County Md. Washiv	naton	10c. City, Town or	Location Hagerst	10d. Inside City Li 5. £OWN 1 □ Yas 2 12						
h with the R	riters deeth with the Me riters 23a or 23a-f a niner must be notified funeral Director	10e. Street and Number 18601 Roxbwry R	5		10f. Zip Code	1746		10g. Citizen of V		?		
ours after deeth raft, or Items 2: Example must	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?	1 Yes 2 No			t of Hispanic Origin? (Specify Yes or No- Cuban, Mexican, Puerto Rican, etc.)			Indian,		
Baitimore, Maryland 21215-0020 semit. Peges 1 and 2 should be filed within 72 hours at Speatment of Heelth and Mental Hygiene. mportant: if item 27 is marked other than "natural", or my houry or other treumatic event, the Medical Example.	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Meryland Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic evant, the Medical Evanther must be notified at once. To Be Completed by Funeral Director	15. Decedent's Elementary/Secondary (0-12)	ade completed)				done during most of working retired)			stry .		
yland 2 ould be filed Mental Hygi arked other atic evant, I	Be Co	17. Father's Nama (First, Middle, Last Henry A. Huffman			cwepene	18. Mother's Nam	ne (First, Middle,	Maiden Suman	ructio	71		
Maryind 2 shouk	To	19a. Informant's Name/Relationship (Katharine E. Sche	Type, Print)		allexis St	and Number or Ru	ral Route Numbe	er, City or Town,		ode)		
Feges 1 and nent of Heelth int: if Nam 27 inty or other tr		20a. Method of Disposition 1 Buriet 2 Cremation 3 Donation 5 Donation 5 Donate (Special	Removal from State	20b. Place of Dis	position (Name of rematory or other pla	ce)	Date	20c. Location -	City or Town			
Baitime permit. Peg Department Important: I any Injury once.		21. Signature of Funeral Septics Line	of the	-	22. Name and Address	ess of Facility	12525 B	radbwry wrg,Md.	Ave.			
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SOX O		resulting in death) Last										
at the deeth cert by the attendir etached for use	Physic	Part II. Other significant conditions of	contributing to death bu	underlying cause gi	ven in Part I.		Did tobacco use contributs to the cause of do					
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n: The ic licate he	Com	Hepahh 25. Was case referred to medical	s Cing	lech'u			101	- 1	101	res 2□ No		
UNISION OF VITAL MECOFICES, Within 24 bours after death, within 24 bours after death. To the Funeral Director: After this certificate hes been signed completely filled in by the funeral director, page 2 should be death.	ation: To Be	examiner? 1 Ves 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Ho spital: 1 1 Inpatier 28a. Date of Injun (Month, Day	/ 28b. Time	of 28c. Inju		ome 5 Resid	dence 6 Oth				
DIVIS tal or Atters as after de- al Diracto	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injubuilding, etc.		street, factory, office		28f. Location (S City or Tox	tion (Street and Number or Rural Route Number, or Town, State)				
Ne Hospi n 24 hou Ne Funer pletely fil	edical	29a. Certifier \(\sum_{\text{Certifying Ph}}\) Certifying Ph 2 Medical Example Medical Examp	ysician: To the best of niner; On the basis of and mannar stat	examination and/or	ath occurred at the til investigation, in my o	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and ma date and placa,	anner as state and due to th	ed. le cause(s)		
Tott within Tott		29b. Signature and title of certifier But 6.	ulivarh,	Ш)	29c. Licens	se number 0 2 3 3		29d. Date signe 215199	d (Month, Da	y, Year)		
11.43		30. Nama and address of person who	completed cause of de	ath (Item 23a) (Typ		hill Ave	Hagers	stown A	1217	42		
Sta Registra	i.e	31. Data liled (Month, Day, Year) FEB 0 8	32. Registra	's Signature	B. In							

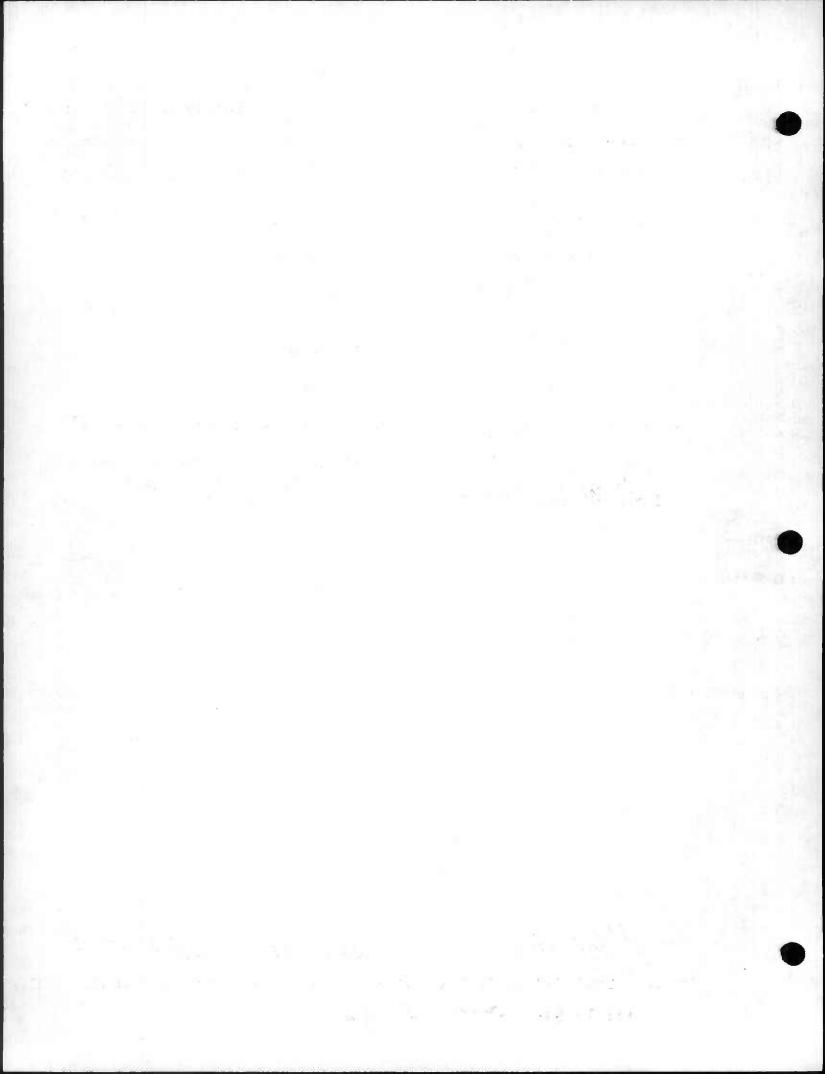


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State of Maryland / Department of Health and Mental Hygiene

Anna Elizabeth Haupt February Total Control of Centre of the Foodity Accounts of Centre of Special Control of Centre of Centr						Ce	rtificate of	Death		Reg	. No.		
ATING ELIZABETH HAUPT Receiver S Memorial Home Receiver S Memorial Home See S S S S S S S S S S S S S S S S S	Dhyalalaa		1. Decedent's Name (First, Middle, L	.ast)						Dete of Deeth		Ves	3. Time of De
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S Sood Search Number 2		٠	Reeders Memorial	Home				Bo	onshor	-0	Wa	shine	oton
The Service of Decoders United Resolution of Decoders United States and Number 11 Association States and Number of United City States and United City States and Number of United City States and Un	eral			Sex	7. Age (In yrs.	lest birthday)		If Under:					wf
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Naryland Washington Boonsboro 10, Epc code		-							- 52		1700	1111	ILLE ILI
Hillier September Septem	4		10a. Stete 10b. County		10c. Cit	ty, Town or Lo	ocation					10	0d. Inside City L
### Common Company Secretary Secreta	tor	1	Maryland Wash	ington	The P			Boonsb	oro				1 ⊠ Yes 2[
Sequentially list conditions	- F									100	. Citizen of V	Whet Coun	try?
### Common Company Secretary Secreta	0		141 South Main	Street				2171	3		T	TSA	
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Ur. E. R. Lardizabal 382 S. Cleveland Avenue, Hagerstown, Maryland 21740/301-739													
State 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture			Dr. E. R. Lardiza 1. Dete filed (Month, Day, Year)	bal 382	S. Clev	veland	Avenue,	Hager	stown.	Maryla	and 21	740/3	301-739
	strar		FEB 0 8 19	399	Deneva	6.	Spark	21					

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mildred February 5, 1999 cation of Death 4c. County of Death Hubbard 6:45 AM 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Loc Salisbury Center: Genesis ElderCare Salisbury Wicomico MD If Under 1 Ve 8. Date of Birth (Month, Day, Year) June 13, 1909 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1□M 20 F Hours Months Days Yrs. 219-07-7997 89 Maryland Usuel Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Maryland Wicomico Salisbury 1X Yes 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 Civic Avenue 21801 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 🖾 No Specify: 3 □Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Laura C. Dean Robert Parks 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Shirley Ann Hastings/Daughter P. O. Box 1407, Easton, Maryland 21601 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 XBuriel 2 Cremetion 3 Removel from State Dorchester Memorial Park 2/7/99 Cambridge, Maryland 4 Donation 5- Other (Specify) 21. Signeture of Fuperal Service Ligari 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 207, 106 Main Street, East New Market, Maryland 21631 Enter the disease, or conclications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only see cause on each line. Part1. shock Approximete Interval Between Onset end Deeth Immediate Ceuse (Finel disease or condition resulting in death) March Due to (or as a consequence of): ert con Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Was an eutopsy performed? 1 Yes 2 1 No 1 □ Yes 2 □ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2₽No 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 3 Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. 29a. Certifier (Check only

Examiner The law requires that the death certificate be executed Box 68760. P.O. Records, Division of Vital or Attending Physician: 24 hours after death.

Funeral Director: A Hospital

Physician

/Medical

Examiner

Director

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Baltimore, Maryland 21215-0020

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DHMH 16 Rev 6/95

William H. Robins, M.D. 31. Dete filed (Month, Dey, Year)

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

29b. Signeture end title of certifier

1104 Healthway Dr. Salisbury, MD 21804 32. Registrer's Signeture

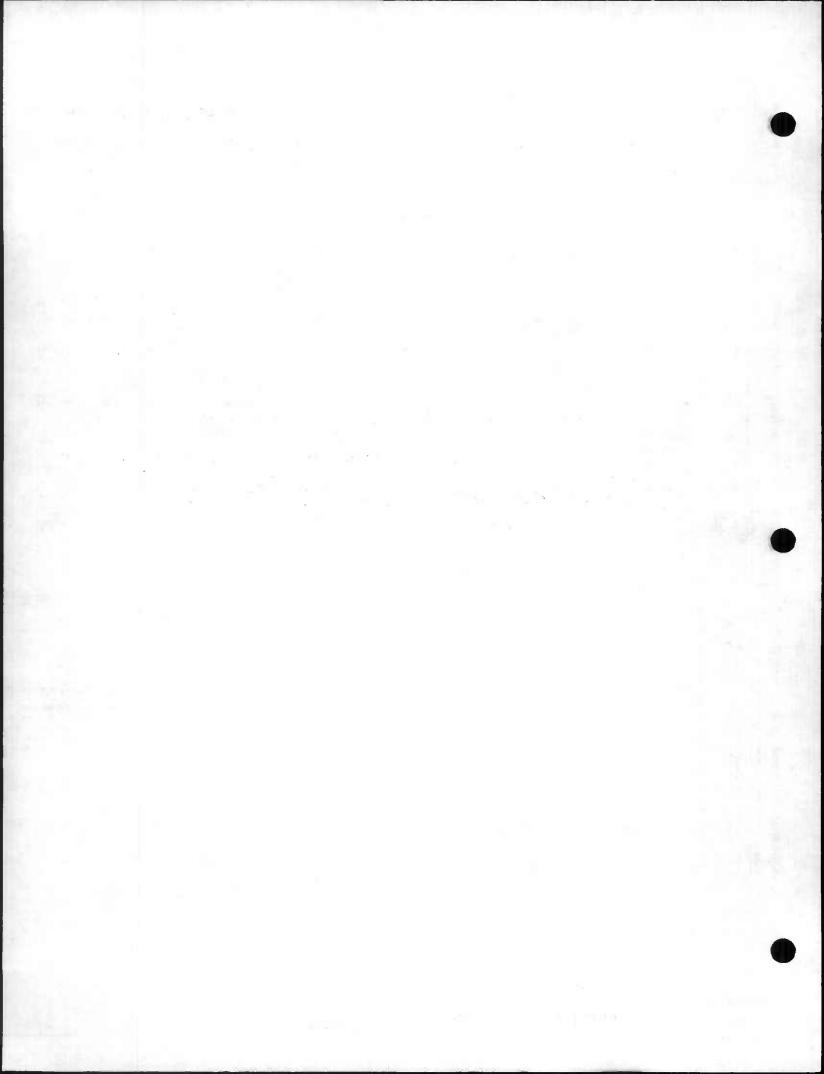
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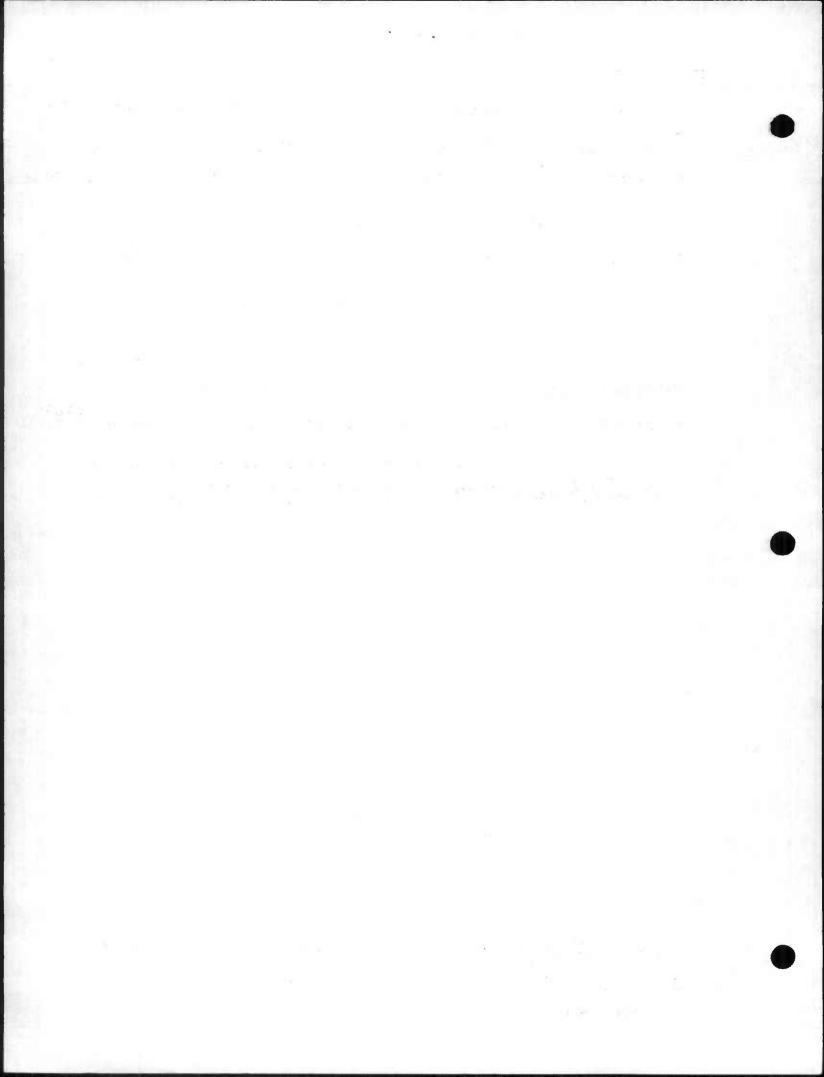
29d. Date signed (Month, Day, Year)

ORIGINAL



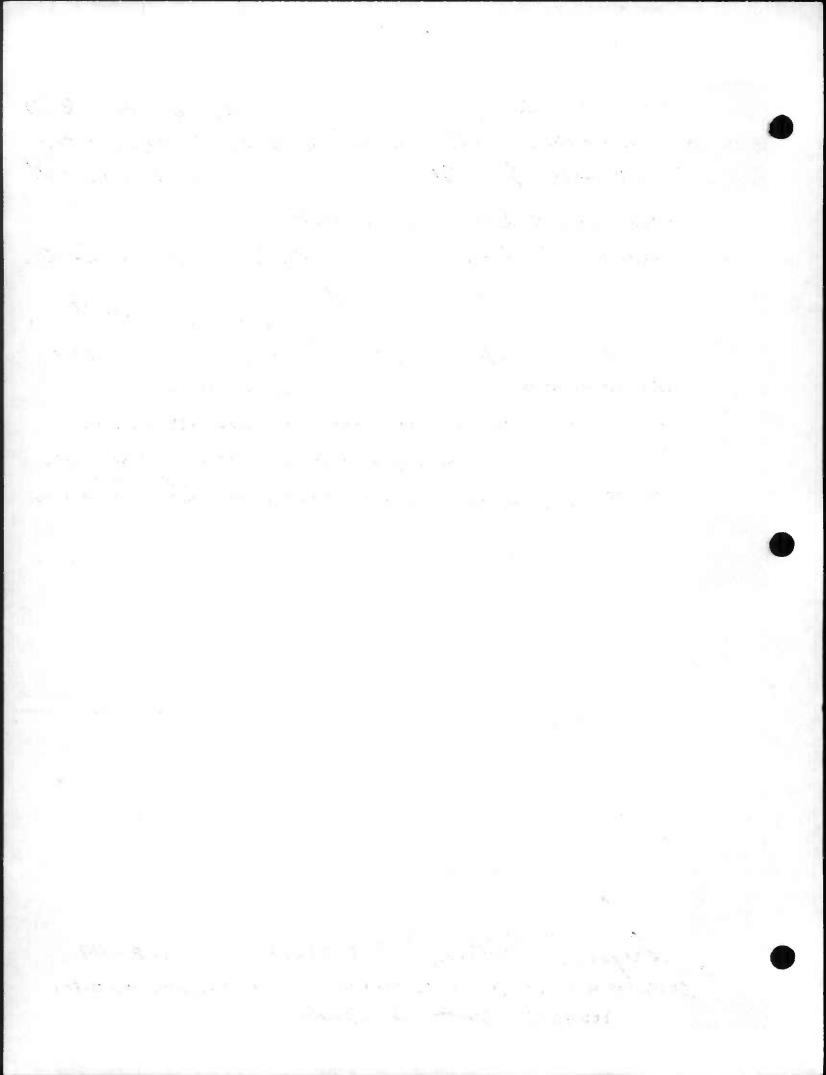
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	Funeral	7	5. Social Security N	umber 6.	Sex	7. Age (In yr.	s. last birthda	y) If Under 1	Year	If Under 24	Hrs. 8. Date of	of Birth				te or Foreign
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g	permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany in ury or other traumatic event, tra Medical otics."		21. Signature of Fu	he A	Dean	moll	29 I		y-M	elson	Funeral Pocomol			MD 218	851	
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		Certification:	 Manner of Deeth Meturel 	5 Pending		h, Day Year)	28b. Time Injury		. Injun		28d. Descr	ibe how i	njury occur	red		
DIVISION	Attending ir death. ector: Affel by tha fune	cat	2 ☐ Accident 3 ☐ Suicide	investigation 6 ☐ Could not be				М	10	Yes 2 □ No						
<u> </u>	i or Attend aftar death Director: / d in by tha i	E I	4 ☐ Homicide	determined	200. Place	of Injury - At h	nome, farm, s	treet, factory, o	ffice		28f. Location	Town, St	t and Numb tate)	ber or Rure	Route Nu	m <i>ber</i> ,
ב	ital curs at the life of ital curs at the life															
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	To the Hospital or Atte within 24 hours after de To the Funeral Directo completaly filled in by th		one)		end menn	er steted.					Courted of the th		ond piece,	OI BUD DITO	ule CeUSO	(9)
	Son Son	Σ	29b. Signeture and t	itle of certifier	16	no	0	29c. L	icense	e number		29d.	Date signe	d (Month, L	Day, Year)	
			rece	goed 1	1. (/20	Class	Mil	D. I	7 2	2950	5		2-/	- GO	7	
		11	30. Name and add	ss of person who	completed cause	of deeth (Ite	m 23e) (Type	, Print)							-	
		4	GREGOR	10 M. BE	LLOSO.	M. D. 3	302	CHINAB	ER	RY DR	SALIS	BUK	RY. M	0 2	180)
	Sta	te	31. Date filed (Month	, Day, Year)	32. Re	gistrar's Sign	eture	,								·

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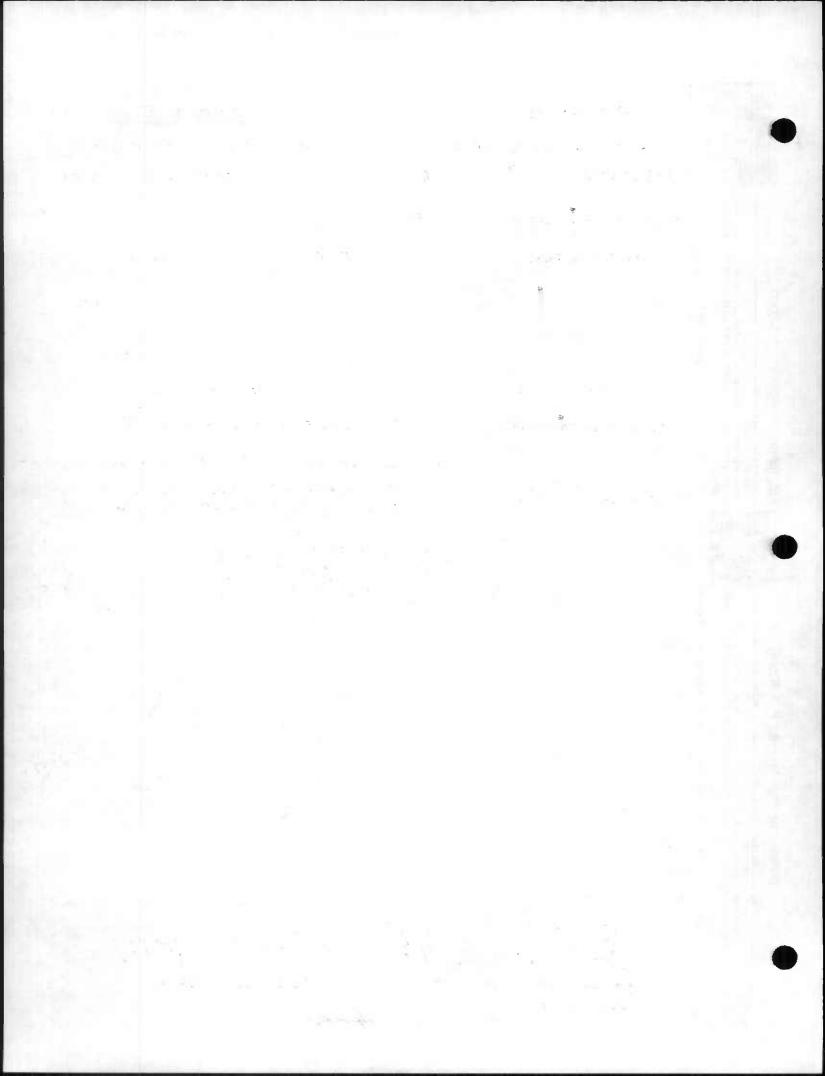
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/Medi		Ethel C.	HOVES			2 6	99	0650
Exami	ner	4e. Fecility Nama (If not institution, give	(SINS + De	hop Conte	4b. City, Town, or Loca	ation of Daath	c. County of Death	
Funeral		5. Social Security Number 6. Se		last birthdey) If Undar 1 Yaer	if Under 24 Hrs.	8. Deta of Birth	Word	
Funeral Director			M 201 9	Yrs. Months Days		8. Deta of Birth (Month, Day, Year 4 6	/7	place (Stata or Foreign ntry)
show		10a. State 10b. County	/ 10c. Cit	y, Town or Location	11.11		1	10d. Inside City Limits
the Maryla 284-1 shon	Director	MD Word	cester	10f. Zlp Code	Dell	10= 0	Wines of Miles Co.	1⊠Yas 2□No
death with the Maryland ms 23a or 28a-f show ground be notified at	rai Dir	430 W M	arket i	St 2	1863	U	itizan of What Cour	States
after or its	by Funeral	11. Maritel Status 1 □ Nevar Married 2 □ Married 3 ♥ Widowed 4 □ Divorced	12. Wes Decedent Ever in U. Armed Forcas? 1 ☐ Yas 2 No If Yes, Giva Yeer or Datas:	,S. 13. Was Decedent of If Yas, specify Cut	Hispanic Origin? (Spec pan, Maxican, Puarto Ri Specify:	ify Yas or No- ican, etc.)	14. Raca - Americ Black, Whita, Specify:	
72 hours	Completed	15. Decedant's Edu (Specify only highest gred	cation	16a. Decedant's Usuel Occu (Giva kind of work done lifa. DO NOT usa retire	pation (seams)	tress)16b.	Kind of Businass/In	dustry
121	mple	Elamantary/Secondary (0-12)	Collega (1-4or 5+)		/	, (1. / 6	7/01
other than	ပိ	17. Fethar's Nama (First, Middla, Last)	NIA	Shiret	ractory		irt 4a	ectory
S sales	Be c	Columbus B. Re	dden			First, Middla, Meider • Melson		
Marylad 2 should the and Merylad Tie market trsumatic	To	19a. informant's Name/Ralationship (T)		19b. Malling Addrass (Stree				Codel
CZNL		Janice F. Ward	(niece)	4932 Creek		now Hill		863
of Health of Health frem 27		20a. Method of Disposition	20b. P	Placa of Disposition (Nama of amatery, cramatory or other pla			ocation - City or To	
Pag Pag ment ant: II		1X Buriai 2 □ Cramation 3 □ F 4 □ Donetion 5 □ Other (Specify)	Sp	ringhill Met	h.Cem. 2,	/10/99 G		
Balti permit. Departm importa any inju		21. Signature of Funeral Sarvica Licens	L. Den	22. Nama and Address Dennis F	ass of Facility Tuneral Ho		O. Box w Hill,	
		23a. Part1. Enter tha diseesa, or compi shock, or heart failura. List only or	cetions thet causad the deeth	h. Do not antar the mode of dy	ing, such es cardiac or	raspiratory arrest,		Approximata Intervel Between
Physician /Medical		immadiata Causa (Finel disaasa or condition		os elevatic (,	Onsat and Daath
Examiner		rasulting in daath)		r as a consaguanca of):	armovas	cular Ju	seere.	s ils
D #	Iner							,
68760, ifficate be executed g physician and as the burlal-transit	Examiner	Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disease or Injury	Dua to (or	r as a consequence of):				
68760, ificate be executing physician and as the burial-tran	edical	that initiated avents rasulting in death) Last	Dua to (or	r es e consequança of):				
O. BOX (No death certified the attending the death certified the attending the death certified to the attending the death certified to the attending the death certified the death certifi	M/ue		l					
deat death	sicis	Part II. Other significant conditions con	tributing to death but not rasu	uiting in the undarlying cause gi	ven in Pert i.	23b. Did tobacco	uss contribute to	the cause of death
d by	y Phy	End Stage	Senile	Tement	and "	1 □ Yes	122	bably 4 Unknow
Records, P.O. Box le law requires that the death cer s has been signed by the attendin tge 2 should be detached for use	Completed by Physician/N	Essential	Hyper	tension		24a. Was en euto performed?	av	ara autopsy findings allable prior to mplation of cause
Rec	дшс		10			4 T V 0	of	death?
of Vital Physicien: T this certificat ral director, pr	Be C	25. Was case rafarred to medical			26. Place of Death (1 Yas 2	IZENO IL	Yas 2 K No
of Vita Physician: this certific	To B	axaminar?	ospital:	ER/Outpatient 3 DOA Ot		a 5 Rasidance	6 □Othar (Specifi	v)
on o ding Ph th. After th	tion:	27. Mannar of Death 1 RNatural 5 Pending 2 Accidant investigation	28a. Data of Injury (Month, Day Year)	28b. Tima of 28c. Inju Wo		d. Dascribe how inju		,,
Division of Vital Rec To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Sulcida 6 Could not be determined	28e. Placa of Injury - At ho building, atc. (Spacify	oma, farm, street, factory, offica		f. Location (Street at City or Town, State	nd Number or Rura e)	al Routa Number,
To the Hospital within 24 hours a To the Funeral I completely filled	edical Ce	29a. Cartifiar 12 Certifying Phys	iclan: To the best of my know	wledga, death occurrad at tha ti ion and/or invastigation, in my o	me, date and placa, an	d dua to the causa(s	and manner as st	taled.
the P the F the F	Med	one) 29b. Signature and title of certifier	and mannar stated.					
To vit		and, Signature and tipe of centimer	000	29c. Licens	se number		ata signed (Month,	2.0
	3	regon la	. Belloso	m. DZ	9505	2	2-6-6	19
	1	80. Name and address of person who co			Pu no to	0 1 1 1001	10011 10 -	0.0
Sta		GREGORIO M. BELL 31. Data filad (Month, Day, Yaar)	32. Registrar's Signat	02 CHINABER		, SALISBI	KY, MD	2180
Registr		FEB 0 8 19	399 Beneva	D. Spor	KN			



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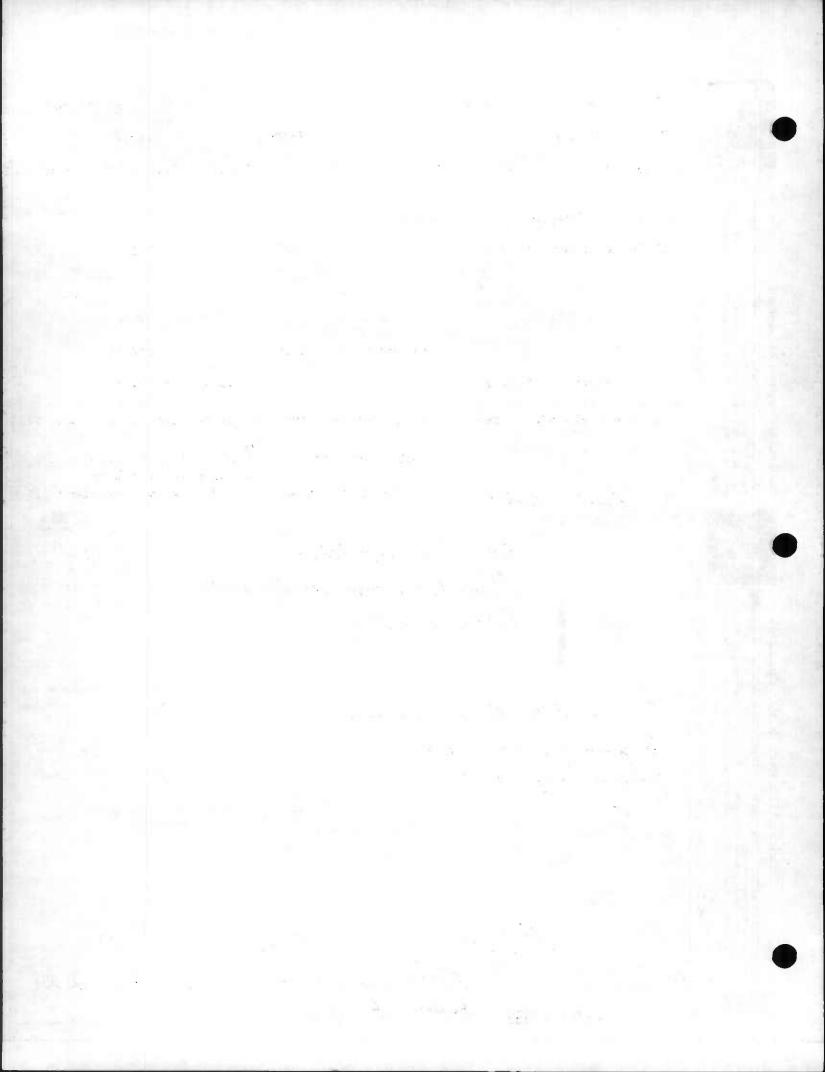
					Certifi	cate of	Death		Reg. No.				
Physician	1. Decedent'a Nan	ne (First, Middle, L	Last)					2. Dete of De Month		3. Tim	ne of Death		
/Medical	R Y 1	ttie May	Jov					Februar	y 8, 1999	2	:30 PM		
Examiner	An Carliby Mann 6		rive street and number)		-	4b. City, Town, or Lo	cation of Deetl	4c. County of				
Examiner		Maraile Nh	ursing Cen	tor			Loopardt	27.772	C+ M	and a			
-	5. Social Security			ge (In yrs. last b	irthday) If	Under 1 Year	Leonardto	8. Date of Bir	St. Ma		ate or Foreign		
Funeral			1□ M 200 F		Yrs. Mo	onths Days	Hours Min.	(Month, De		9. Birthplaca (Sta Country)			
Director	212-74- Usual Residence of			94				January	15, 1905	Marylan	d		
Pu s	10a. State	10b. County		10c City To	wn or Locatio	n				10d Insid	de City Limits		
anyle din			. 1								Yes 2 No		
Of o	Maryland	St. M	lary's	H	lollywo	ood				'0	162 5401140		
vith the Main or 28a-fa	10e. Street and Nu	<i>im</i> ber			10	Of. Zip Code			10g. Citizen of Wh	at Country?			
ath with the Marylar 23a or 28a-f show ust be notified at	25044	Morgan R	hens			2063	6		U.S.A.				
within 72 hours after death with the Maryland ene. Then "netural", or items 23a or 28e-f show the Medical Evantine must be notified at ampleted by Funeral Director	11. Marital Status	norgan i		Ever in U.S.	13. Was I			ecify Yes or No		14. Raca - American Indian,			
urs after deal	1 News Mas	ried 2 Merried	12. Was Deceden Armed Forces 1 Yes 2	?	If Yes	s, specify Cube	lispanic Origin? (Spo en, Mexican, Puerto	Rican, etc.)	Bleck,	White, etc.			
urs aft			If Yes, Give		101	Yes 20 No	Specify:		Specify:	Whit			
Trail d		4 L Divorced	Year or Dates:								Le		
ed within 72 hours ygiene. er than "netural", 4, the Medical Exa Completed by	(Soe	15. Decedent's lecify only highest g	Education trade completed)	16	 Decedent's (Give kind) 	s Usual Occup	ation during most of work	ina	16b. Kind of Business/Industry				
d within 72 hours af jiene. Ir than "natural", or the Medical Evan.	Elementary/Sec		College (1-4or	5+)	life. DO N	IOT use retired	during most of work						
filed withithy Hygiene. Ither than the Man, the Man ent,	8th				Homema	aker			Own I				
		(First, Middle, Las	st)				18. Mother's Name	e (First, Middle	Maiden Sumeme,				
Mental H Mental H arked ott atic ever	Stanhan	Enders	McGee				Estelle	Marr	Palar				
d 2 should be file h and Mental Hy T le marked oth traumatic event						toto Tin O - d - 1							
2 sho and le ma	19e. fnforment's N	ame/Helationship	(Type, Pnnt)	19	b. Mailing Ad	ddress (Street	and Number or Run	ai Houte Numb	er, City or Town, S	tate, Zip Code)			
C = 20 -	Randy	Johnson/	Nephew				Road, Ho	11ywoo	d, MD 206	36			
attrit. Pages 1 a Spartment of Hee mportant: if Nem iny Injury or othe	20e. Method of Dis			20b. Place	of Disposition	n (Name of ny or other plac	na)	Date	20c. Location - C	ity or Town, Stat	te		
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portant: Pag portant: I w Injury c				Joy		1 Ceme		2/11/9	HOTTA	wood, Ma	arylan		
Separin Separin mporta my inju	21. Signature of Fr	neral Service Lig	ensee A			me and Addre	ss of Facility 7-Gardine:	c Eupon	al Llomo	D A			
88204	Mu	brack X	Hardin	er									
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/Medical Examiner	Immediate Cause disease or condition	on	· Can	xia	un	mare	1 ank	we		all	90		
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ficate be executed to physician and a the burial-transit edical Examine	Sequentially list or if any, leading to it cause. Enter Und	inditions, mmediate		Due to (or as	consequence	serof)	V			//			
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physician is the burial	that initiated event resulting in death)	16	41	Due to (or as a	consequeno	oe of):				-			
- CR 65													
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by the darkached	Part fl. Other sfgni	ficant conditions	contributing to death	but not resulting	in the under	lying cause giv	en in Part I.	23b. Dld	tobacco use cont	ribute to the cau	use of death		
that the seed by datac								1 🗆	Yes 2 00	3 ☐ Probably	4 Unknow		
iras that signed t d be dat													
								24a. Wes	en autopsy	24b. Were euto	psy findings		
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The law ta has bage 2			1				26. Place of Deet	h (Check only)	nne)				
in: The law requir ificata has been s or, page 2 should e Completed	25. Was case refe	rred to medical	-			Ott	or.						
centificata has rector, page 2	25. Was case reference examiner?	rred to medical	Hospital:			DOA I	4 Nursing Ho	me 5∐Resi	denca 6 Other	(Specify)			
hysiclan: his certific al director To Be	25. Was case reference examiner?	(No		1 Inpatient 2 EH/Outpatient 3 DOA 4/2 Nursing H									
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ling Physician: After this certific funeral director ilon: To Be	25. Was case reference examiner?	(No	28a. Date of Inj (Month, D	ury 28b	Time of Injury	28c. Injur Wor	y at k? Yes 2 □ No	28d. Describe	how injury occurre	d			
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DHMH 16 Rev 6/95



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	Decedent's Name (First, Middla, Last)		Certificat			2. Data of De		3. Time of Death	
/sician	Edna May Ka	naga				Feb		99 9:25PM	
ledical aminer	4a Facility Nama (If not institution, give street and number	er)			4b. City, Town, or	Location of Death	4c. County of	Death	
	Pines Facility				Easton		Talb		
al or	214-09-7380 1□M 2⊠F	Age (In yrs. las	Yrs. If Under Months	1 Year Days	If Undar 24 Hrs Hours Min.	8. Data of Bir (Month, De October	th Year) 12,1901	New Jersey	
	Usual Residence of Decedent 10a. Stale 10b. County	10c. City,	Town or Location					10d. Inside City Limits	
20	Maryland Washington	Нао	erstown					NO Yes 2 No	
Director	10e. Street end Number	1100	10f. Zip	Code			10g. Citizen of Wh	at Country?	
	222 North Potomac Street				21740		U.S.A		
by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 1 □ Yes 2 If Yes, Give Yaar or Date	es? Š No	13. Was Dece If Yes, spe 1 \(\subseteq Yas		lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yas or No o Rica <i>n</i> , atc.)	14. Race - Black, Specify:	American Indian, Whita, etc. White	
etec	15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usu (Give kind of wo	al Occup rk dona	ation during most of wo	rking	16b. Kind of Bust	ness/Industry	
Completed	Elementary/Secondery (0-12) College (1-40	or 5+)	executive				aircra		
	17. Father's Name (First, Middle, Last)		CACCULIVE	360		ne (First, Middle,	Maiden Sumeme)		
o Be	Harry Fetzer					Laura	Schmie	dt	
-	19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address	(Street	ete, Zip Code)				
	Mrs. Joan Wieland/daughter	r	18538 Ind:	8 Indian Cottage Road, Hagerstown, Ma					
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Sta	te	ce of Disposition (Nametery, crematory or o	other pla		Peb.	20c. Location - C		
	4 □ Donation 5 □ Other (Specify)	Rose	e Hill Cem			3,1999		wn, Maryland	
	21. Signature of Funeral Service Licansee				ilson Bl	Minnich	Home Maryland 2174		
	23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	sed the death.						Approximata Interval Between	
	Immediate Cause (Final disease or condition resulting In death)	ngestiv		1	There we called			Onset and Death	
Examiner	Sequentially list conditions, if any, leeding to immediate cause. Entar Underlying Cause (Disease or injury		as a consequence of:		as accent	ausewse.		years	
Aedical	Cause (Diseese or injury that initiated events resulting in death) Last		as a consequenca of):		TI LECT			years	
and	d								
Physician/M	Part II. Other algnificant conditions contributing to death			_				ibute to the cause of death? B Probably 4 Unknown	
eted by	Pulmonary emboli,	chron	monery d	,,,,,			an autopsy ormad?	24b. Were eutopsy findings evallable prior to completion of cause	
Completed	Vertebral compression	frad	uros			10	Yes 2 No	of death? 1 □ Yes 2 No	
ation: To Be	25. Was case referred to medical axaminer? 1		R/Outpatient 3 Do	28c. Injui Wo	ner: 45 Nursing I		one) denca 6 □Other how injury occurred		
Certification:	3 ☐ Suicida 6 ☐ Could not be determined 28e. Place of building.	Injury - At hometc. (Specify)	ne, farm, street, factor	y, office		28f. Location (City or To	Street end Number wn, State)	or Rural Route Number,	
edical C	29a. Certifier (Check only one) Certifying Physicien: To the be and manner	of examination							
Z e	29b. Signature and title of certifier	1	29	c. Licens	se number		29d. Data signed	(Month, Day, Year)	
	Men	slen	The said	1	72593	33	2.6	99	
completely filled in by the Medical Certifical	30. Name and address of person who completed cause of	of death (Item 2	23a) (Type, Print)	^	Avinin) 1-	action N	10 Dient	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Charles R. Keller February 8, 1999 7:55 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HAGERSTOWN WASHINGTON Homewood at Williamsport 9. Birthplece (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 6. Dete of Birth (Month, Day, Year) May 16, 1912 5. Social Security Number Days Hours 1₩ 2□ F 86 Yrs. 217-10-9012 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limita 1 ☐ Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16505 Virginia Avenue 21795 U.S.A. 12. Was Decedent Ever In U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Married 1□ Yes 2□ No Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Coilege (1-4or 5+) Elementary/Secondery (0-12) Manager Electric 17. Father's Name (First, Middle, Last) 16. Mother's Name (First, Middle, Maiden Sumeme) Daisy Thomas Amos Remsberg Keller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Keller/son 13429 Windsor Drive, Hagerstown, Maryland 21742 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☑ Donetion 5 ☐ Other (Specify) e of Funeral Service Licensee Ronald S. Wade 22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street 21. Signature of Funera Director Baltimore, Maryland 21201 Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth EPSIS wo To Three Immediate Cause (Final disease or condition resulting in death) Pue to (or as a consequence of): NEUMONIA Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): WEAKNES MANGES Due to (or es e consequenca of): MORE Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 2HE (ONE) MENTIA 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? 2 1 NO 1 □ Yes 2 □ No.

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

ð

Funeral

Director

7 is marked other than "naturel", or items 23s or 28s-f ahow traumatic avent, the Medical Examiner must be notified at

Peges 1 end 2 should be filed within nent of Health end Mentel Hygiene. Int: If Item 27 Ie merked other than "I

other t

Depertment of Important: If It any Injury or o

Maryland 21215-0020

ed by the ettending physician and deteched for use es the buriel-transit been signed by should be detec

Examiner Physician/Medical þ Completed this certificete has director, funeral Certification: death. or Attender efter deatl Director:

25. Was case referred to medicel 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c, Injury at Work? 1- Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier

29b. Signaturo and interest

1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

EDICA MECTU 29c. License number 29d. Date signed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print)

METERICA!

31. Date filed (Month, Day, Year) State

8 1999

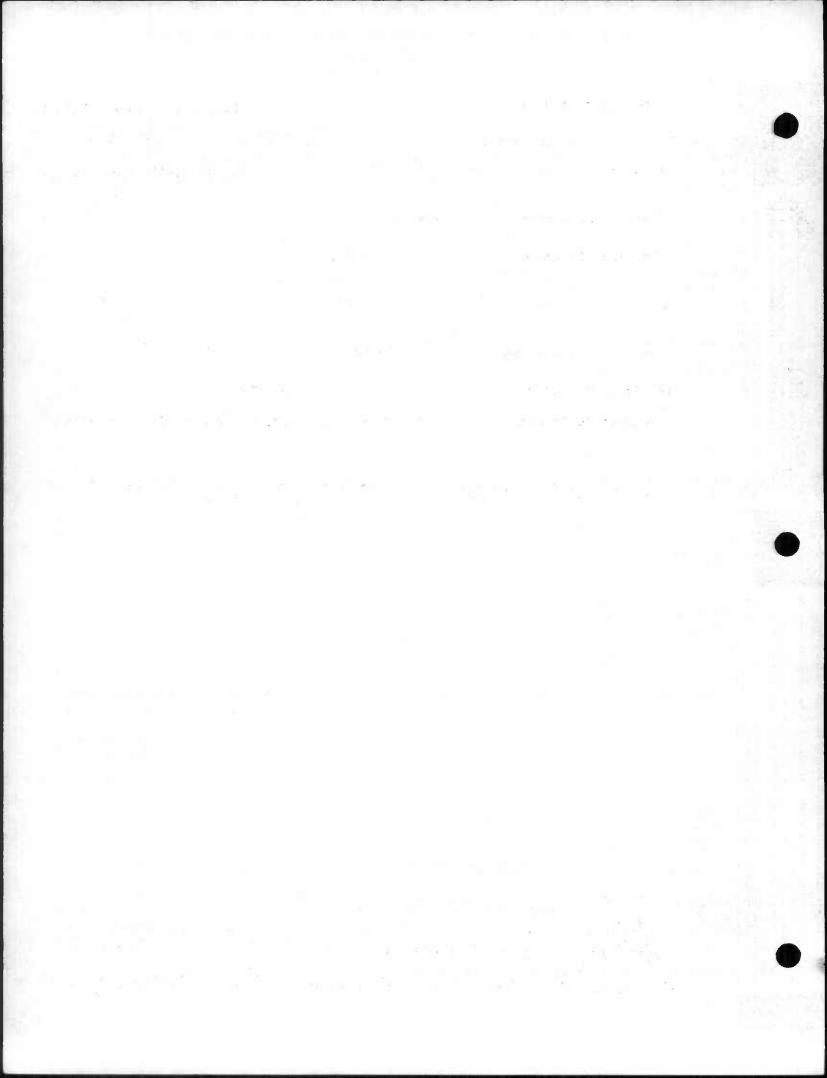
32. Registrar's Signature

Registrar

filled in

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To the Hospital of within 24 hours of To the Funeral Dicompletely filled in

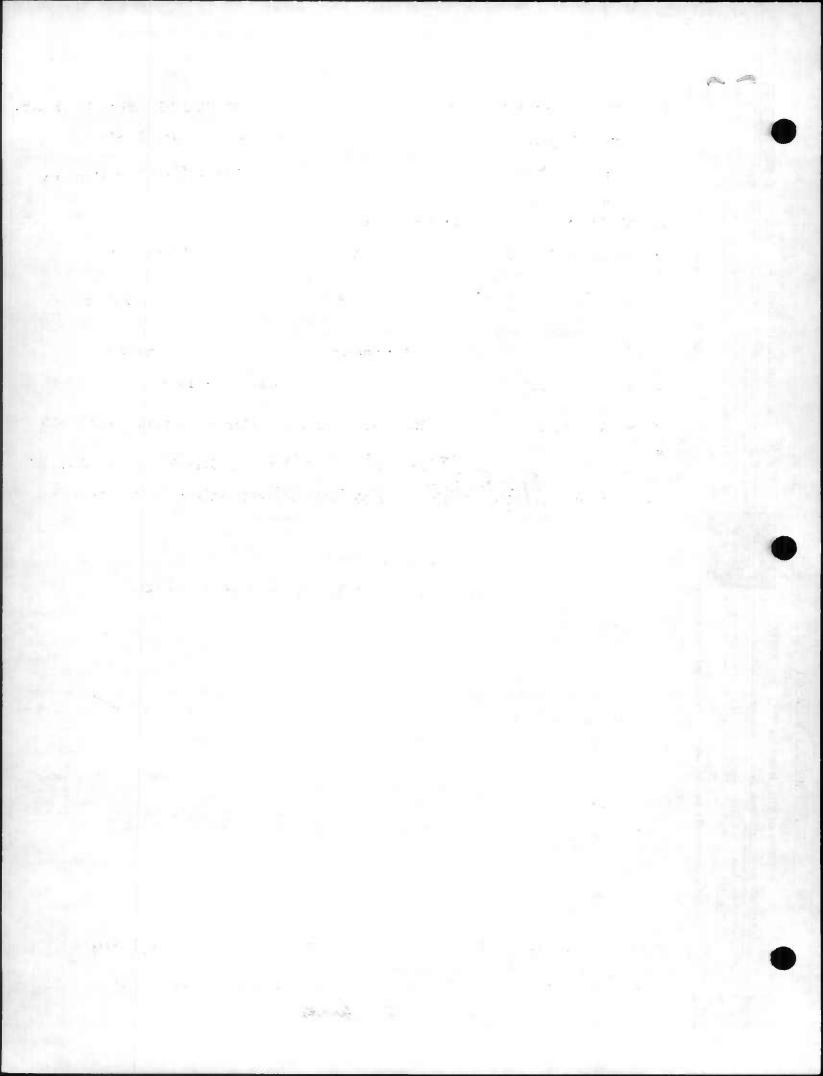


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State of Maryland / Department of Health and Mental Hygiene 9 0 5 0 2 7

Physician	Amended #8, 2/9/99 1. Decedent's Name (First, Middle, Las	(t)		ate of Dear	2. Data o	Day	3. Time of Death
/Medical Examiner	Frederick Ve 4e Facility Name (If not institution, give St. Mary's Hospi				FEBRI Town, or Location of C ardtown	JARY 05, Death 4c. County St. M.	of Deeth
Funeral Director	5. Social Sacurity Number 6. Se	ax 7. Aga (In yrs.	lest birthday) If Ur 2 Yrs. Mont	ider 1 Yaar If Und			
death with the Marylend rms 23s or 28s-f show rmsst be nothing at	10a. Stata 10b. County		ty, Town or Location	rk			10d. Insida City Limits 1 ■ Yes 2 □ No
th with th	10e. Street end Number 20771 Wolftrap St	reet		Zip Code 0653		10g. Citizen of Philipp	
P 5 1	3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		scedent of Hispenic specify Cuben, Mexi s 2 la No Spec	Origin? (Specify Yes o can, Puerto Rican, etc ify:	.) Ble	ce - American Indien, ck, White, etc. Y Philippino
iane. than the Men	15. Decedent's Ed (Specify only highest grave) Elementary/Secondary (0-12)		16e. Decedent's U (Give kind of life. DO NO Accoun	work done during n T use retired)	nost of working	16b. Kind of B	usiness/Industry ting
should be filed and Mental Hygin marked other umatic event, To Be Co	17. Fether's Neme (First, Middle, Last)	ee			other's Nama (First, Mi	ddla, Maiden Sumer Velasco	na)
d 2 should the and Men 7 is marke traumatic	19a. Informent's Neme/Relationship (7	ype, Print)			mber or Rurel Route N		
eges 1 an ant of Heel tt if item 2 y or other	Rufina Lee/ Wife 20e. Method of Disposition 1 Burial 2 Cremation 3 Companies 4 Donation 5 Other (Specify 21. Signature of Funeral Service Lican	Removal from State	Plece of Disposition (cometery, cremetory) naculate H Cemetery	Neme of or other plece)	lary Feb.13	20c. Location	ryland 20653 - City or Town, Stete ngton Park, MD
pemit. P Departms Importan any Injur	Mary B. Rizzo	THUY D. KIZ				e.P.A.	Maryland20650
requires that the death certificate be executed with the death certificate be executed with the detected for use as the buriel-transit attended for use as the buriel-transit attended by Physician/Medical Examiner	Cause (Disaese or injury that initieted events resulting in death) Lest	b. Due to (or es e consequence	of): Y T J Z of):	lethal	anhych	Onset end Deeth
ires thet the death ce signed by the attend d be detached for us		ontributing to death but not res	sulting in the underlying	ng cause given in Po	en I. 23b.	Did lobacco use co	ontribute to the cause of death?
The law requires the law been single has been single page 2 should Completed	COPD			3	24a.	Wes an eutopsy performed?	24b. Were eutopsy findings eveilable prior to completion of cause of deeth?
Physician: The is this certificate har all director, page: To Be Com	25. Wes case referred to medical exeminer? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☑	ZER/Outpetient 3□	Other:	lece of Deeth (Check of Nursing Homa 5		1 Yes 2 No
After fune	27. Menne_efDeath 1	28e. Deta of injury (Month, Day Year)	28b. Tima of Injury M	28c. Injury at Work? 1 ☐ Yes 2	28d. Desc DNo 28f. Locat	ribe how Injury occu	
To the Hospital or Attentivity 24 hours efter death within 24 hours efter death completely filled in by the Medical Certifical		reiclan: To the best of my known iner: On the basis of examination of the properties of examination of the properties of					
within Toth Complete	29b. Signetura and titla of certifier	Poged m		29c. License numb			ed (Month, Dey, Year)
) B	30. Name and address of person who come PAGE m.	o st.mi	arys Hu	SPITAL	LEOWIPO	town, or	00 2065 On
State	31. Dete filed (Month, Day, Year)	32. Registrer's Sign	etura	South!			

LEE, FREDERICK VELASCO



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State of Maryland / Department of Health and Mental Hygiene

						C	ertificate	of	Death		Re	g. No.				
Phys		ш	Decedant's Nama (First, Middla, La: Mary Agnes Morni		No. of				9		2. Data of Death	n	199 ^{9ar}		ne w Deeth 500	
	edical niner		e. Facility Nama (If not institution, give	a street and number)					4b. City, Tov		ocation of Death	-	ounty of Death			
Exam		ı	Avalon Manor Nurs	sing Home					Hao	ers	town	Wash	ningtor	Cou	inty	
Funer Direct	_		i. Social Sacurity Number 6. S			last birthda 93 Yrs.	Months	Yaar Days	If Under 2			Year)	9. Birth		ata or Foraign	
Maryland a-f show	tor	1	Oa. Stata 10b. County Maryland Washingt	on County		gerst									da City Limits Yes 2 No	
th with the 23s or 28	at Dire	1	0e. Street and Numbar 14014 Marsh Pike				10f. Zip (742		10		of What Cou JSA	ntry?		
Iore, Maryland 21215-0020 ges 1 end 2 should be filed within 72 hours after deeth with the Manyland at of Health end Mental Hygiene. If Itam 27 is marked other than "natural", or items 23a or 28=-f show or other traumetic event, the Medical Examinar must be northed.	hy Fineral Director	1	Marital Status Navar Married 2 Marriad Widowad 4 □ Divorced	12. Wes Dacedant E Armed Forces? 1 ☐ Yas 2 ②N If Yas, Giva Yaar or Datas:		S. 1:	3. Wes Decede if Yas, specif			in? (Sp , Puerto	ecify Yas or No- Rican, etc.)		Race - Ameri Black, Whita, becify: Wh		ın,	
5-0 72 hc	Completed		15. Decedant's Ed (Specify only highast gra	fucetion da completed)		16a. De	cedent's Usual	Occu	pation during most	of work	ina	6b. Kind	of Businass/In	dustry		
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Maryland 2. Id 2 should be filed w Ith end Mental Hygie 77 is marked other ti traumatic event, in	To Be		7. Fethar's Nama (First, Middle, Last) Edgar John Mornir								H. Mani		mama)			
end 2 shoalth end 27 is m			19a. Informant's Name/Reletionship (Mary J. Della Tof		in	19b. Ma 119	ailing Addrass (27 Iroq	Straa [UO:	is Ave	ror Rur nue,	al Routa Number, Smithsbu	city or To	own, Stata, Zij Iarylan	d 21	783	
Baltimore, Maper I and 2. Department of Health en Important: If item 27 is	×	2	0a. Mathod of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		C	emetery, c	sposition (Name tramatory or oth urg Cre	ar pla		F			ion - City or To sburg,			
Balt permit. Departri	SUCS.	2	21. Signature of Funeral Service Licen	sue Contraction			22. Nama and 1331 Ea	Addr	ess of Fecility	Dou	glas A. N., Hage	Fier	y Fune wn, Mar	ral ylan	Home d 21742	
Physicia	ın	1	23a. Part1. Enter the disease, or comp snock, or heart tallure. List only	olications that causad ona causa on each lin	lha daath									Approx		
/Medica		l.	Immadiata Causa (Final disaasa or condition													
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X 68760, certificate be ex ding physician se as the burial	/Medical	r	het initiated avants asulting in death) Last	d	Oua to (or	as a cons	sequance of):									
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IS, P.O. BO; es that the death or igned by the attend be deteched for us	v Physician/		art II. Other significant conditions of	ontributing to death bu	t not rasu	ilting in The	a undariying ca	usa gi	van in Part i.						use of death?	
cord requir been s should	Completed by	-									24a. Was ar perform		a\ cc	ailabla p	psy findings rior to n of ceusa	
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of Vital Inysician: The vis certificate I director, pag	9	2	5. Was cesa referred to medical axaminer?								h (Chack only on	*				
of of others of this call direct	2		1 Yas 2 No				ient 3 DOA				ma 5□ Rasida			fy)		
Division of Vita or Attending Physician: ther deeth. Director: After this certifical in by the funeral director,	Certification:	2	7. Mannar of Death 1		Year)	28b, Tima Injun	of 28	c. Inju Wo 1 [iryat ork?]Yes 2 □ N		28d. Dascribe ho	w injury o	ccurred			
Division Hospital or Attending 24 hours efter deeth. Funeral Director: After tely filled in by the fune	Certific		3 ☐ Suicida 6 ☐ Could not be datarmined	28a. Place of Inju building, atc	ry - At ho . <i>(Specify</i>	ma, farm,	streat, factory,	office			28f. Locallon (Str City or Town		lumbar or Rur	al Route	Numbar,	
Division or To the Hospital or Attending Ph within 24 hours efter deeth. To the Funeral Director: After thi completely filled in by the funeral	edical		29a. Certifiar 1☐ Caitifying Phy (Check only one) 2☐ Medical Exam	yaician: To the best of liner: On the basis of and manner sta	axaminat	vledga, da ion and/or	ath occurred al Invastigation, I	tha ti	ima, data and opinion, daat	place, h occurr	and due to the ca ed at the time, da	usa(s) an	d mannar as a ace, and dua t	stated. o tha cau	use(s)	
To the To the Comp	Σ								se number				igned (Month,			
		-ton DISOIG FEBRUARY									٤ , ر-	179				
			O. Nama and address of person who of Vasant Datta, M.D.					sto	wn Ma	rvl	and 2174	n				
S Regi	State strar	3	1. Date mad (Month, Day, Year)	32. Registra	r's Signat	ura			racks		21-14					

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State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month Day February 6, 1999 **Physician** Erva Edith McKinney 8:50 PM /Medical 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner St. Mary's Nursing Center St. Mary's Leonardtown If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) November 12, 9. Birthplace (State or Foreign Country)
Washington, DC **Funeral** 10 M 20 F Months Days Hours 577-03-7805 83 1915 Director Usual Residence of Decedent with the Maryland 10a State 10c. City. Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f ahow odical Examiner must be notified at 1 Yes 2 No Maryland St. Mary's Leonardtown Directo 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 21649 Rosalie Way 20650 U.S.A. Peges 1 and 2 should be filed within 72 hours effer death tent of Health and Mentel Hygiene. Funeral 14. Race - American Indian, Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Detes: Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: by 3 Widowed 4 □ Divorced White Hygiene. other than "nature ent, the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Yrs. Homemaker Own Home 7 is marked other traumatic avent, in 18. Mother's Name (First, Middle, Maiden Sumame) 17 Fether's Name (First Middle Last) Be William Hiles Pardoe Rosalie Sanner Foxwell 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health a Pam Howe/Daughter 21649 Rosalie Way, Leonardtown, MD 20650 Item 27 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Peges Department of Important: If Its any Injury or o 1 Buriai 2 Cremation 3 Removal from State 2/8/99 4 Donation 5 Other (Specify) Metropolitan Crematory Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility.
Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 lande 23a. Part1. Enter the dampine, or compshock, or heart failure. List only Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete Intervei Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner to (or as a consequence of): Examiner -6 well that the death certificate be executed physicien end s the burial-trens Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequence of): ettending pl signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown by The law requires 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en autopsy performed? Completed is certificate has director, pege 2: 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ves 2 No 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this 28e. Date of Injury (Month, Dey Year) funerel 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how Injury occurred Certification: Affer 5 Pending investigation 15 Natural death. 1 Yes 2 Accident after death Diractor: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 24 hours a Funeral D Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) end manner as stated.

| Medical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) of death (Item 23a) (Type, Print) 30. Name and address Boyd James C MD Van an

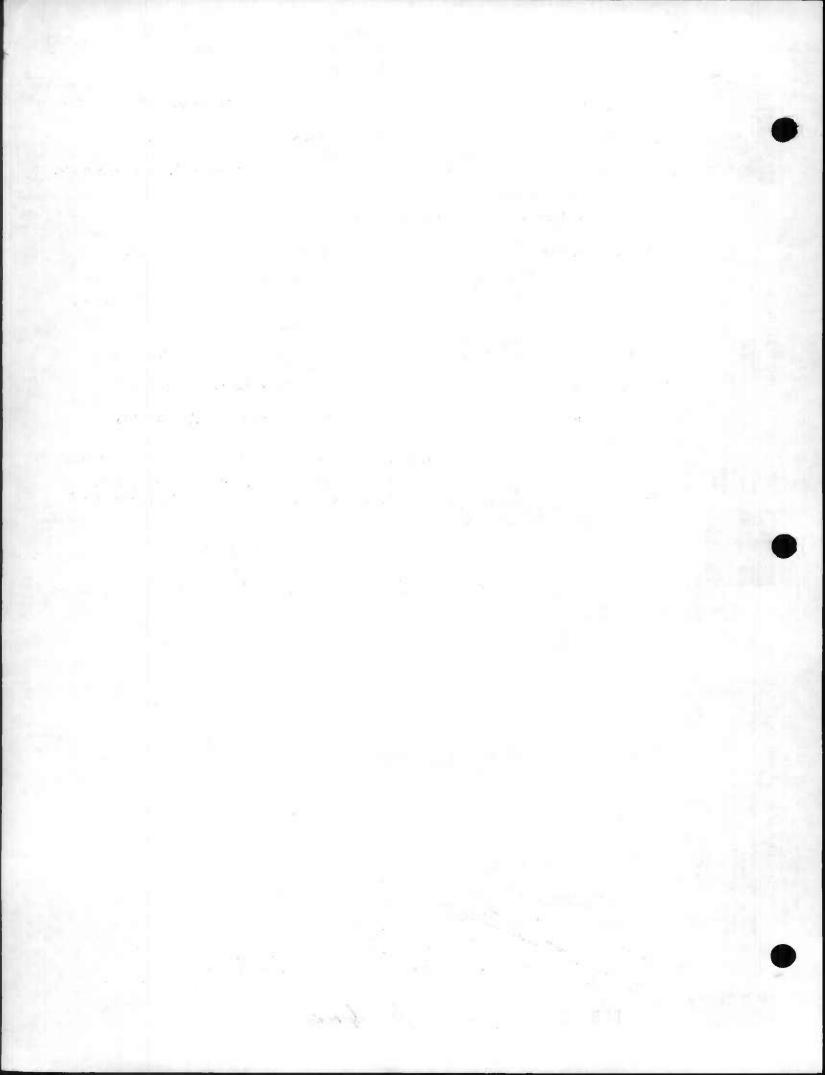
Registrar

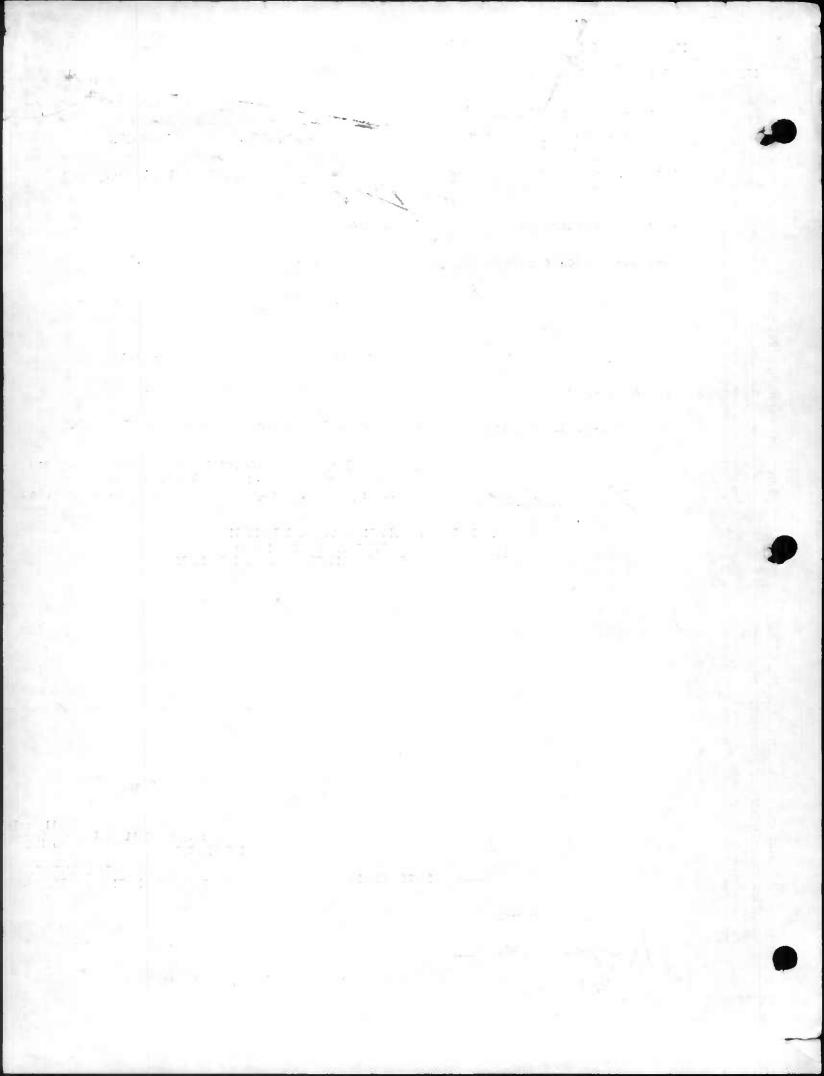
31. Date Hed (Month Day, Year)

FEB

8 1999

12. Registrar's Signeture





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 4b. City, Town, or Location of Death 2215 Mary Alice MOORE /Medical 4e Facility Neme (If not institution, give street and number) 4c. County of Deeth **Examiner** Washington County Hospital Washington Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days 1 □ M 2 🖺 F Hours Months Yrs. 90 Director Dec. 29 1908 215-14-1858 Maryland Usuel Residence of Decedent with the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🖾 No Director Maryland Washington Sharpsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 105 W. Antietam Street 21782 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. filed within 72 hours after 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: þ 3 ☐Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 8 0 Toy Manufacturer Assembler permit. Peges 1 and 2 should be file Department of Health and Mentel Hy Important: If Itam 27 is marked oths any injury or other traumatic avent, pince. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Della M. Drenner Charles R. Renner 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) James M. Moore - Son P.O. Box 599 Funkstown, Maryland 21734 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 2/9/99 Hagerstown, Maryland Hagerstown Crematory 22. Name and Address of Facility Minnich Funeral Home 21. Signeture of Funeral Service Licensee 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** tmmediate Ceuse (Final disease or condition resulting in deeth) money /Medical Cerebro varied D Examiner Due to (or as e consequence of) Examiner atheropelerous physician and the burial-transit Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thel Initiated events resulting in death) Lest Due to (or es e consequence of) Box 68760. Physician/Medicai Due to (or es e consequence of) esn P.O. Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown tailer Records. P The law requires 24b. Were eutopsy findings eveilable prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital or Attanding Physician: 25. Wes case reterred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 □ ER/Outpatient 3 □ DOA After this 28e Dete of injury (Month, Day Year) 27. Member of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Neturel 5 Pending 24 hours after death.

Funeral Director: A 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide filled in Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steled.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and menner steled. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 16 Rev 6/95

State Registrar 31. Dete filed (Month,

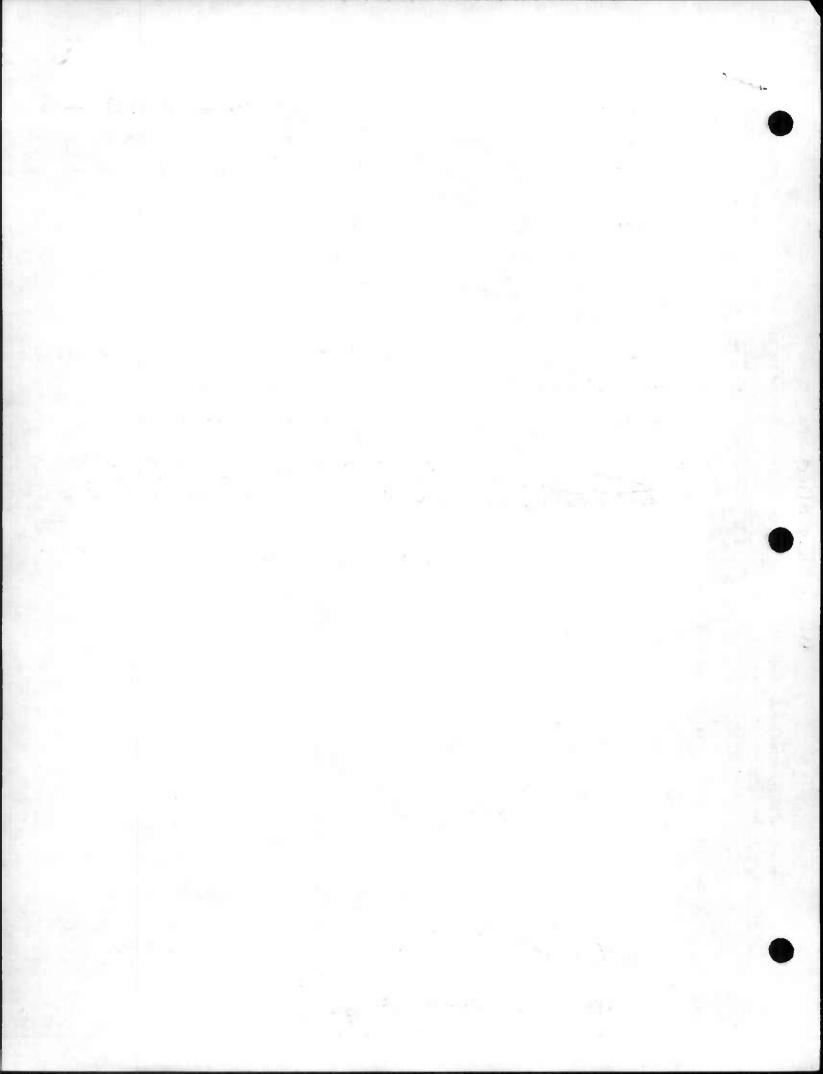
deserble m

30. Name and address of person who completed cause of peath (Item 23a) (Type,)Print)

100

Gletin

32. Registrar's Signature

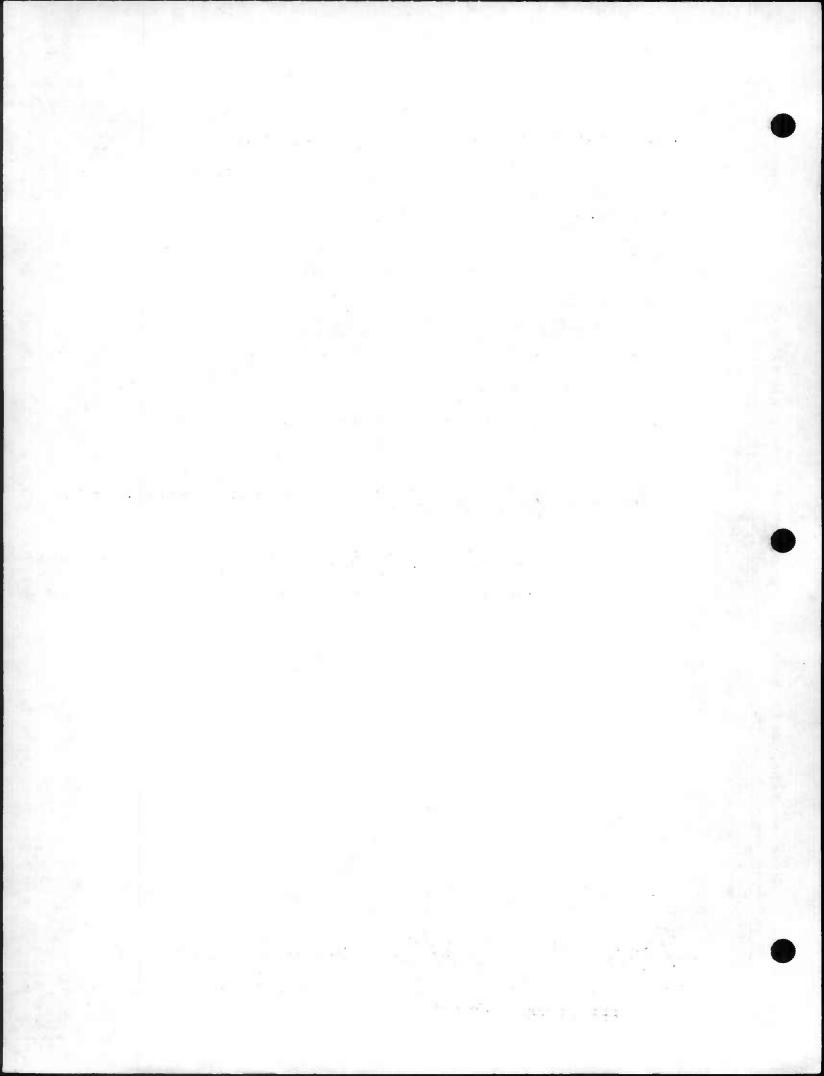


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day Month Yaar **Physician** Plantary 6 1-1-1, Martha Irene MILLER 1245 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Jan. 26, 1912 7. Aga (In yrs. last birthday) Birthpleca (Stata or Foraign
Country) **Funeral** Days Months Hours 1□ M 2⊠ F 87 214-09-5040 Yrs Pennsylvania Director Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Smithsburg Maryland Washington 1 ☐ Yas 2XXNo Director or 28a-f 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 64 East Water Street 21783 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - Amarican Indian, Black, White, atc. 1 Navar Married 2 Married 1 ☐ Yas 2 ☑ No If Yas, Giva 8 21215-0020 Specify: white 1 Yes 2 No Specify: 3 ☐ Widowed 4 🖾 Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education
(Specify only highest grade complated) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) dressed & repaired shoes shoe manufacturer 0 - 4altimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumema) Be Pages 1 and 2 should be nent of Health and Mental is marked Alfred Bruce Provard Lillie Viola Mummert 19a. Informent's Name/Ratationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) Department of Health, Important: If Item 27 Is any injury or other tra Mrs. Barbara Rohrer/granddaughter 800 Security Road, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cematary, crematory or other place) 20c. Location - City or Town, Slata 1 Burlal 2 □ Cramation 3 □ Ramoval from State Feb. Cedar Lawn Memorial Park 1999 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funaral Sarvice Licensee 22. Nama and Address of Facility Minnich Funeral Home East Wilson Blvd., Hagerstown, Maryland 21740 UNMAG 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximata Interval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Physician/Medicai Due to (or as a consequence of) Part It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Tonknown should be det þ Completed 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Dage 2 1 ☐ Yas 2 ☐ No certificate 1 Yas Division of Vital or Attending Physician: 25. Was casa referred to medical axaminar? Be 26. Place of Death (Check only one) ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yas 1 Inpatient this 28a. Data of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1-Watural 5 Pending invastigation 24 hours after death. 1 Yes 2 No 2 Accidant 6 Could not be datermined 3 Suicida 28a. Ptace of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Hedical Examiner: On the basis of examiner, and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a, Certifiar (Check only one) Within 2 To the I ş 29c. License number 29d Date signed Month, Day, Year) 100 Year) **FEB 0 9** Registrar



REG. NO.

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Lest)

hours after death. Page 6 may be completely executed within HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be

BARRY

31. DATE FILED (Month, Day, Year)

M. COHEN MO

FFB 0 9 1999

2. DATE OF DEATH 3. TIME OF DEATH 1999 February 6, Naomi Blanche MURFREE 1230 A M 7. DATE OF BIRTH
(Month, Day, Year)
Dec. 4, 1906 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 579-10-1758 DAYS HOURS MONTHS Maryland 1 M 2 X F 92 YRS. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 7115 University Blvd. Keedysville Washington DIRECTOR RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Washington Hagerstown 1X YES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 10f, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1024 Brinker Drive 21740 U.S.A. burial-transit retained by the hospital or attending physician. 11, MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—
If yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Married specify: white 1 YES 2 NO Specify: BY 3 🖾 Widowed 4 🗌 Divorced the ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY use (Specify only high (Give kind of work done life. Do NOT use retired.) jo Elementary/Secondary (0-12) College (1-4 or 5+) unknown homemaker her own home detached once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Albert Spong Grace Bowers page 5 should be 7 notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Mr. Robert R. Spong/brother 7115 University Blvd., Keedysville, Maryland 21756 pe 20a. METHOD OF DISPOSITION
1 B Burtst 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cametery Feb. 20c. LOCATION — City or Town, Stata cametery, crematory or other place) Church 10,1999 Hagerstown, Maryland must funeral director, 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 Tred L Veiter filled in by the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory street, shock, or heart feiture. List only one cause on each line. Approximate interval Between **IMMEDIATE CAUSE (Fine)** Onset and Death the disease or condition B. ACUTE MOCHABIAL INFARCTION, SUSTECTED

DUE TO (OR AS A CONSEQUENCE OF): reaulting in death) 50015N other traumatic event, and com b. AATENOSCUENCE OF: YEHRS CERTIFICATION CARDIONAS CULAR DISEASE Sequentielly list conditions, Hygiene prior to if sny, lesding to immediate cause. Enter UNDERLYING physician CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): thet initisted events attending resulting in death) LAST 6 certificate has been signed by the atten h the State Dept. of Health and Mental ! d, or Item 23 shows any Injury, o PART if. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24h. WERE AUTOPSY FINDINGS 24s. WAS AN AUTOPSY AVAILABLE PRIOR TO COMPLETION DF CAUSE 1 YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO TUNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL OTHER: 1 YES 2 410 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 A Realdenca 6 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this c marked, 1 Natural 5 Pending NONS 1 YES 2 NO BY DIRECTOR: After thours after death item 28 is mar 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide 29a. CERTIFIER
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) end manner as stated. TO THE HOSPITAL OF THE FUNERAL DE BE filed within 72 he IMPORTANT: If it 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month. Day, Year) BE 02-08-99 Ne D01040 9

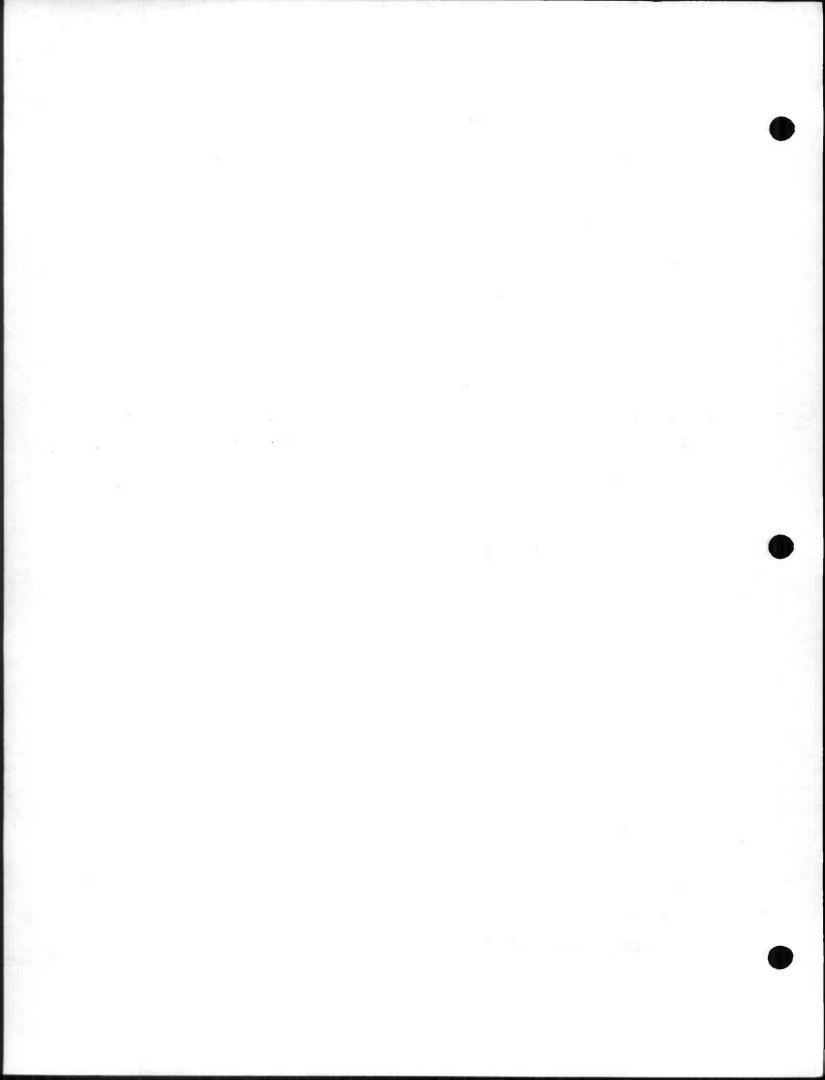
WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

18706 CRESTWOOD DAILY

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH**

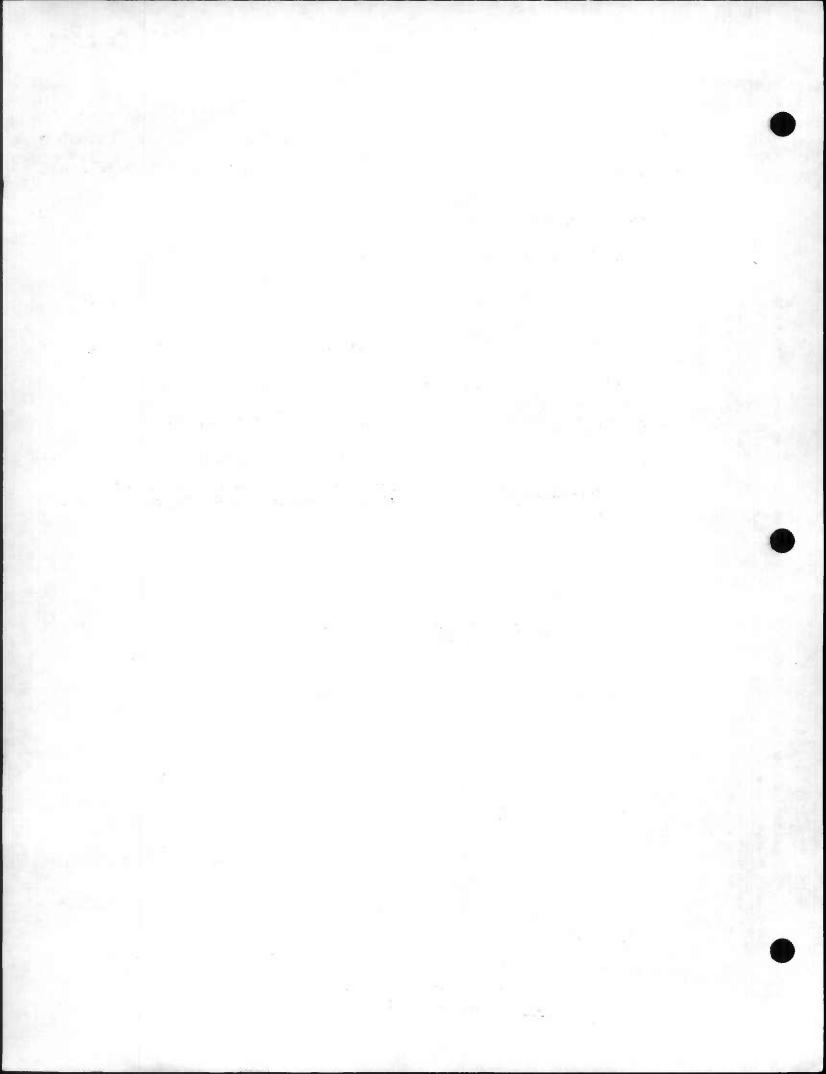
HAGOISTOWN, MD, 21742



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mer	ntal Hygiene
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	Certificate of Death	Reg. No.												
THE RESIDENCE	Decedent'a Nama (First, Middle, Last)	2. Dete of Deeth	3. Time of Death											
Physician	PEARL FRANCES MUSER	Month Dey	1999 00:50											
/Medical Examiner	45 English blame //f and institution also attend and aumber)		nty of Death											
Examiner	Washington County Hospital Hagerst	own Wa	shington											
Funeral	5 Social Security Number 6 Say 7 Ana (In urs lest hirthday) If Under 1 Year If Under 24 Hrs.	8 Date of Birth												
Director	217-10-1302 1 M 2 F 82 Yrs. Months Deys Hours Min.	April 16, 1916	9. Birthplaca (Stata or Foreign Country) Maryland											
bug *	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits											
land land			1 ☑ Yas 2 ☐ No											
vith the Ma t or 28a-f s be notified	Maryland Washington Hagerstown 100. Street and Number	40- 014	^											
4 0 M	Tot. Street and Number		f Whet Country?											
O after death w re flems 23e	38 East Franklin Street 21740	U.S												
Production of the production o	11. Meritel Stetus 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specific Yas, specify Cuban, Mexican, Puerto	Rican, atc.)	ace - American Indian, leck, White, etc.											
020 um	3 A Widowed 4 Divorced Year or Dates:	Spec	white											
121215-0 ed within 72 ho sysjena. her than "naturi it, the Medicell.	15. Decedent's Education 16a. Decedent's Usuel Occupation (Specify only highest grade completed) (Give kind of work done during most of work)	16b. Kind of	Businass/Industry											
12 miles	(Specify only highest grade completed) (Give kind of work done during most of work in the control of the contr													
Manual No.	11 Homemaker	Ow	n Home											
De file doth	17. Fether's Nema (First, Middle, Last)	(First, Middle, Maiden Sum												
Vla Went Ment Ment Ment	Richard Howard Marston Lillie	H. Eva	ns											
S sho	19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rura	al Route Number, City or Tow	m, State, Zip Code)											
M , Maith	Linda D. Meldron 862 Dewey Avenue, Hager	rstown, Md. 23	1742											
of Ha	20b. Plece of Disposition (Name of cemetary, crematory or other place)	Deta 20c. Location	- City or Town, Stete											
Page nant in it.	1X Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) Rest Haven Cemetery 02	2-08-99 Hagers	stown. Maryland											
Baltimore, semil. Pagas 1 ar apparant of Haa mportant: if then 2 my injury or other ans.	21. Signetura of Funeral Service Licensee / 22. Name end Address of Fecility													
Bal Permi Depa Impo eny ir	R. hoel Brady Andrew K. Coffman													
	40 East Antietam Street, Hagerstown, Md. 21740 23a. Part1. Enter tha disaase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart feilure. List only one cause on each line. Approximate Intervel Batween													
Physician /Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in deeth) a. Due to (or as a consequence of):	mot () or	Onset end Death											
Cords, P.O. Box 68760, requires that the death certificate be associted been signed by the attending physician and should be detached for use as the bunal-transit letted by Physician/Medical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last C. Dye to (or es a consequence of):	10.10 kg	NO IV											
D. E a des	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did tobacco uae d	contribute to the cause of death?											
S, P.O. Bost that the death ined by the atter se detached for we have steen by Physician		1 □ Yee 2 □ No	3 Probably 4 Unknown											
De de pe de V														
Vital Records, sicion: The law requires to cartificate has been signe irector, page 2 should be to be Completed by		24a. Was an autopsy performed?	24b. Ware autopsy findings aveilable prior to											
O & 2 0 Q			completion of causa of death?											
Vital Rec		1 ☐ Yes 2 M No	1 ☐ Yes 2 ₺ No											
/ita		(Check only ona)												
Of Vita Of Vita Physicien: This carific	Hospital: 10 Proprient 20 ED Other: 40 Number	me 5 ☐ Rasidence 6 ☐C	ther (Specify)											
Ion of Vital Rec		28d. Describe how injury occ	urred											
VISION Attending or death.	1-Kelvel 5 Pending (Month, Day Feat) Injury Work? 2 Accident Investigation M 1 Yas 2 No													
Division of Divisi	3 Suicide 4 Homicida 6 Could not be determined 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Nur City or Town, State)	mber or Rural Route Number,											
Cer and of the control of the contro	Duriding, etc. (Opecity)	ony or roun, oldio,												
Hospi Hospi Raly fill Cal	29e. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) Certifying Physician: To the basis of examination and/or investigation, in my opinion, deeth occurred and manner stated.	end dua to the causa(s) and a ed et the time, date and place	menner as stated. e, end due to the ceuse(s)											
To the within 2 To the comple	29b. Signetura and titla of certifier) 29c. License number	29d. Date sign	ned (Month, Day, Year)											
FSFÖ	M8 Bun, M.D. D0053071	02/1	5/00.											
		10	71/											
	30. Name end address of person who completed cause of death (Item 23a) (Type, Print) MAKERDAN, M.D. IIIIO Medico) Compus & 2006, 1003 31. Dete filed (Month, Day, Year) See 1999 32. Registrer's Signature	note in												
State	31. Dete filed (Month, Day, Year) 32. Registrer's Signature	POSIONN M)												
Registrar	31. Dete filed (Month, Day, Year) FEB 0 8 1999 32. Regisfier's Signature	-												
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State of Maryland / Department of Health and Mental Hygiene 99

							Ce	ertificate	of Death			Reg. No.						
		Physic	ian	1. Decedent's Name (First, Middle, L						:	2. Dete of De		Yeer	3. Time of Death				
		/Medi		Robert Fulton	Middlekau	ff				1	12	4	99	1300				
		Exami	ner	4e. Fecility Neme (If not institution, g							ation of Deet							
				Washington Cour			to a biat do) If Under 1 Y		ersto				n County				
		Funeral Director	Н	214-09-9035	Sex 1⊠M 2□F	Age (In yrs.	86 Yrs.		ear Ir Orider	Min.	Month, De Nov • 1	th ly, Year) 1,1912	9. Birthpla Counti Mar	ace (State or Foreign ry) yland				
		and w		Usuel Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or L	ocation					10	Od. inside City Limits				
		Ba-f sho	Director	-	gton Co.		agerst	own						1 X Yes 2 □ No				
		death with the Maryland ms 23a or 28a-f show	ai Dire	1535 Kensington	Drive			10f. Zip Co 21	742			10g. Citizen of US		ry?				
	07	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if ferm 27 is marked other than "natural", or items 23a or 28af show any injury or other traumatic svent, the Medical Examiner must be notified as once.	Funerai	11. Marital Status 1 ☐ Never Married 2 ☑ Merried	12. Was Decede Armed Force 1 X Yes 2 if Yes, Give	s?	l,S. 13.	Was Decedent If Yes, specify			ity Yes or No ican, etc.)	14. Rad Ble	ce - America ock, White, e					
	000	ural',	d by	3 ☐ Widowed 4 ☐ Divorced	Yeer or Dete	s:					Specify.							
1	15	n 72	Completed	15. Decedent's I (Specify only highest g	Educetion rede completed)		16e. Dece	edent's Usuel O e kind of work d DO NOT use re	ccupation one during mos	at of working	7	16b. Kind of B	usiness/indu	ustry				
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9035	and	d be filed intal Hyg ed other	Be	17. Fether's Name (First, Middle, Las Frank R. Middle			Daire	.b repre	18. Mothe			, Meiden Sumer		ridis riig.				
	7	should Me Me mark	2	19e. Informent's Name/Relationship			19b. Mail	ling Address (St	reet and Numb	er or Rural	Route Numb	er, City or Town	State Zin (Code)				
00	Ž	nd 2 alth ar 27 is		John B. Middlek										d 21740				
	Baltimore, Maryland 21215-0020	ages 1 a ant of Hee t: If Item y or othe		20e. Method of Disposition 1 ☐ Buriel 2 ☆Cremetion 3 3 4 ☐ Donetion 5 ☐ Other (Special Control of Control o	□Removal from Sta	te c	Place of Disponentery, cre	osition (Name of emetory or other arg Crem	f plece)		Dete 'eb.6	20c. Location	- City or Tow					
214	alti	mlt. Fortan		21. Signature of Funeral Service Lice				2. Name end A					, m= 5, .					
5	Ö	Depar Impor any ir		b/ Journe	1/ Fini		1	331 Eas	tern Bl	vd.,N	I., Hage	erstown,	Mary	land 21742				
3				23a Hartl. Enter the disease, or con shock, or heart failure. List only	mplications that cause	sed the deat	h. Do not er	nter the mode of	dying, such es	cardiac or	respiratory e	rrest,		Approximete Intervel Between				
4	Physician			Sill of Hook laboro. Elst sill										Onset end Deeth				
		/Medical Examiner		Immediate Ceuse (Final disease or condition	Pros	state	2 (carci	mom	a				5 4rs.				
		LAUIIIIICI	<u>.</u>	Immediate Ceuse (Final disease or condition resulting in death) e. Prostate carcimoma 5 475 Due to (or es e consequence of):														
		9 #	nine	b														
	-	be executician and burlal-tran	Examine	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury c.														
1,	68760	icate be execu- physician and s the burlai-tra		thet initieted events	c	Dua to /o		augus offi										
1	×	5 55	/Medical	resulting in deeth) Lest	d	Due to (o	er es e conse	querice or):										
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no	0	by the darked tached	hys	Pert II. Other significent conditions	contributing to death	n but not res	ulting in the	underlying ceus	given in Pert I	l.		.1		the cause of death?				
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B	Rec	The law ate has page 2	idmo									4	of de	leeth?				
3	ta	tolan: The lav certificate has rector, page 2		25. Wes case referred to medical	T					10.4	10	/ \	1	Yes 2 No				
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e Kan	Jo L	g Phys er this seral d		27. Manger of Death	28e. Dete of in		28b. Time o		injury et Work?			how injury occur		,				
1	io	andin self.	atio	1 Neturel 5 Pending investigation	on	Day (ear)	Injury		1 Yes 2	No								
de	Division	after de Birecte din by t	Certification:	3 Suicide 6 Could not determined	be d 28e. Plece of building,	Injury - At he etc. (Specif	ome, ferm, st	treet, factory, of	ice	28	If. Location (: City or Tou	Street end Numi vn, State)	ber or Rurel	Route Number,				
8		To the Hospital within 24 hours . To the Funeral completely filled	edicai C	29e. Certifier Contrying P	hysician: To the beaminer: On the basis	of exemine	wledge, deat	th occurred et th	e time, dete en ny opinion, dee	d plece, en	d due to the l et the time,	ceuse(s) end mo	enner es ste end due to	eted. the cause(s)				
		within To the	₩.	29b. Signature and the of certifier	/	stolou.	0 /	29c. Lic	ense number			29d. Date signy	nd (Month, D	Jay, Year)				
				1/ Time	16um	and	4. ph	1-011.	DI	759		2/4	1199	7				
				30. Neme and address of person who	completed cause o	f deeth Dran	n 23a) (Type	Print)				-17	111					
				George C. Newman	Jr.,Ph.	D., M.	D., 1	1110 Med	dical C	ampus	R. Ha	gerstow	n, Mar	yland 2174				
		Sta		31. Dete filed (Month, Dey, Year)	32. Regy	trer's Signa	iture	4	uls									
		Registi	ar	FEB 08	וככנו		~	. 1000	uns/									

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DOS: 01/22/99

NAME: MIDDLEKAUFF, ROSERT FULTON DOS

_							Ce	rtifica	ate o	t Death		Reg. No.		
П	Physic	ian	1. Decedent's Name (Fin								2. Data of De Month	ath Day	Yaar	3. Time of Death
V	/Medi		GRACE	TRU						MIHALIK	FEBRUAR		1999	2:20 PM
1	Exami	ner	4a. Facility Name (If not a Berlin N				itation	Cen	ter	4b. City, Town, or Berlin	Location of Death		y of Death rcester	
	Funeral Director		5. Social Security Number 214-32-04	75 ¹	ex □M2 X F	7. Age (In ye	s. last birthday, Yrs.	If Und Month	der 1 Ye is Day			y, Year)	9. Birthplac Country	(State or Foreign
	land		Usual Residence of Dece 10a. State 10b	County		10c. (City, Town or Lo	cation					10d	I. Inside City Limits
	Mary	to	WV	Jeffer	son		Boliva	_					1.00	1 XYes 2 □ No
	r 28s	rec	10e. Street and Number	301101	3011		DOMAG	1	Zip Code	9		10g. Cifizan of	What Country	17
	3a o	D E	301 Poto	mac Te	rrace	Ante			254	25		US		
070	filed within 72 hours after death with the Maryland Hygiana. ther than "natural", or itema 23a or 28s-f show int, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4	. ☐ Married	12. Was Dece Armed Fo 1 Tes If Yes, Giv Year or D	edent Ever in rces? 2 X No		Was Dec	cedent o	f Hispanic Origin? (Suban, Mexicen, Puer	specify Yes or No to Rican, etc.)		ce - American ick, White, etc	
5	72 ho	eted	15. [ecedent's Ed	ucetion de completed)		16a. Dece	dent's Us	sual Occ	supation ne during most of wo	rkina	16b. Kind of E	Businass/Indus	stry
1212-0020	e filed within at Hygiana. other than " vent, the Mes	Completed	Elementary/Secondary	(0-12)	College (1	-4or 5+)	life.	DO NOT	use reti	ector			Gover	nment
a	a la b	To Be	17. Fathar's Name (First,		Truitt						ne (First, Middle, e Perry	Maiden Surna	me)	
3	~ 0 5 6		19a. Informant's Name/F	alationship (7	ype, Print)		19b. Maili	ng Addre	ss (Stre	et and Number or Ru	ıral Route Numbe	er, City or Town	, State, Zip Co	ode)
	CENL		E. Glen Mi	halik/	Son					Harpers	Ferry,	WV 25	125	
	T of of		20a. Method of Disposition 1 ☑XBurial 2 ☐ Cre 4 ☐ Donation 5 ☐ 0	mation 3 🗆		State	Place of Dispo cemetary, creating airview	natory o	r other p	ran Cemet	/13 / 99 erv	20c. Location Bolivai		, State
	permit. Peg Department Important: If any injury o		21. Signature of Funeral	Bu	chase			108	3 Wi	ress of Facility	Burbag Berlin,	MD 218		ne
			23a. Part1. Enter the dis shock, or heart failu	re. List only o	rications that come cause on a	eused the de ach line.	ath. Do not en	er the m	ode of d	ying, such as cerdiad	or respiratory ar	rest,	In	pproximate iterval Between
	Physician /Medical Examiner		Immediate Cause (Final disaase or condition resulting in death)		me	etni	Lat	ru	Di	sanst-	to Bro			Monset and Daath
ć	certricate be executed ding physician and use es the buriel-transit	Examiner	Saquentially list condition if any, leading to immediaceuse. Entar Underlying Cause (Disease or injury that initiated events	es, ate	b. Bn	mch	(or as a consection of a conse	0	1): 42	cinoma d				
,00700	refuricate by inding physic use es the bi	n/Medical	that initiated events resulting in death) Last	1	C	Due to	(or as a conseq	uance of	i):					
-		lan			d								i	
5	mer me deem led by the ette detached for	Physicia	Part II. Other significant	onditiona co	ntributing to de	ath but not re	sulting In the u	nderlying	ceuse	given in Part I.	23b. Dld 1	obacco uae co	entribute to th	ne cause of death?
,	as thet me deem gned by the ette be detached for	by Ph	CIRIL	no U	iseul	nh	A.c.	dh	1		1/4	Yes 2□ No	3 Probab	oly 4 Unknow
5	e law requiras me has been signed I ga 2 should be det	Completed									24a. Was perfo	an autopsy med?	avalla	autopsy findings able prior to letion of cause ath?
	cate ha										101	es 21 No	1 □ Y	as No
	this certificateral director, pag	Be	25. Was case refarred to examinar?	-						28. Place of Dea	th (Check only o	ne)		
	this c	2	1 ☐ Yes 2 No		Hospital: 1 🗆 Ir	patient 2	☐ ER/Outpatier	t 3□ [JUA		ome 5 Rasio	lence 6 □Ott	ner (Specify)	
	Bu and and		2 Accident	Panding Investigation	28a. Date o (Monti	f Injury h, Day Year)	28b. Tima of Injury							
	vithin 24 hours effection of the four vithin 24 hours effect death. To the Funeral Director: A completely filled in by the four four filled in by the filled in by the four filled in by the filled in by the four filled in by the filled in	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place building	of Injury - At g, etc. (Spec	home, farm, str ify)	et, facto	ory, office	Э	28f. Location (S City or Tow		ber or Rural R	oute Number,
0	in 24 hour	edical	29a. Certifier 124 C (Check only one)	ertifying Phy edical Exami	sician: To tha i ner: On the ba and mann	sis of examin	owledge, death ation and/or inv	occurre	d at the	time, data and place opinion, death occu	, and dua to the c rred at the tima, o	ceuse(s) and m date and place,	anner as stata and due to the	d. a cause(s)
3	o the		29b. Signature and title of	certifier				2	9c. Licer	nse number		29d. Date signe	d (Month, Day	v. Year)

D02026

21811

30. Name and address of parson who complated cause of death (Item 23e) (Type, Print)

FEDERICO G. ARTHES, MD 46 TEAL CIRCLE, BERLIN, MD

32. Registrar's Signature

21099

410-641-4400

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ITEM: #26 PER MD G768 2-18-99 WR. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Death Month 29 1999 WILLIAM HENRY MILES January 10:15 AM 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Civista Medical Center LaPLata Charles 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 9. Birthplece (State or Foreign March 24,1921 Washington, DC 7. Age (In vrs. last birthday) 9. Birthplece (State or Foreign 1**X** M 2□ F Deys Hours 577-22-8335 Yrs. Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Waldorf 1 Yes 2 No Charles Maryland 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 4859 Leonardtown Road 20601 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Automotive College (1-4or 5+) Mechanic Self-Employed 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Isaac Miles Annie Hyde 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie R. Miles/Wife 4859 Leonardtown Road, Waldorf, Maryland 20601 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State Lincoln Cemetery 02-02-1999 Bladensburg, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee Name and Address of Fecility
The Huntt Funeral Home, Inc O M01098 P. O. Box 156, Waldorf, Maryland DAVID A. GOFF 20604 23a. Part1. Enter the diseese, or complications that cause the shock, or heart feilure. List only one cause on each line Do not enter the mode of dying, such es cardiac or respiretory errest, Approximete Intervel Between Onset end Deeth Immediete Ceuse (Finel diseese or condition resulting in death) nau Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last te Due to (or es e consequence of): 23b. Did tobacco uee contributa to the cause of death? 200 No 1 Yes 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy performed? completion of ceuse of deeth? 20 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. Stete

Director

Funeral

p

Completed

Be

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

"natural',

permit. Peges 1 end 2 should be filed within Depertment of Health end Mental Hygiene. Important: If Item 27 Is marked other than 'any Injury or other traumatic event, tra Me

Peges 1 end 2 should be 1

the Maryland

buriel-trensit end physician certificate be the 98 ding use etten for signed by the c peed aw pege 2 s The certificate To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Physician/Medicai

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Completed

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Certification:

Medical

Box 68760.

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Records,

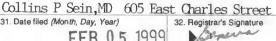
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Pert II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 25. Wes cese referred to medical 26. Piece of Death (Check only one) Other: 4 Nursing Home 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28c. Injury et Work? Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 5 Pending investigation Maturel 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Phyelclan: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) end menner stated. 29a. Certifier 29b. Signeture and title of cartifier

State Registrar

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

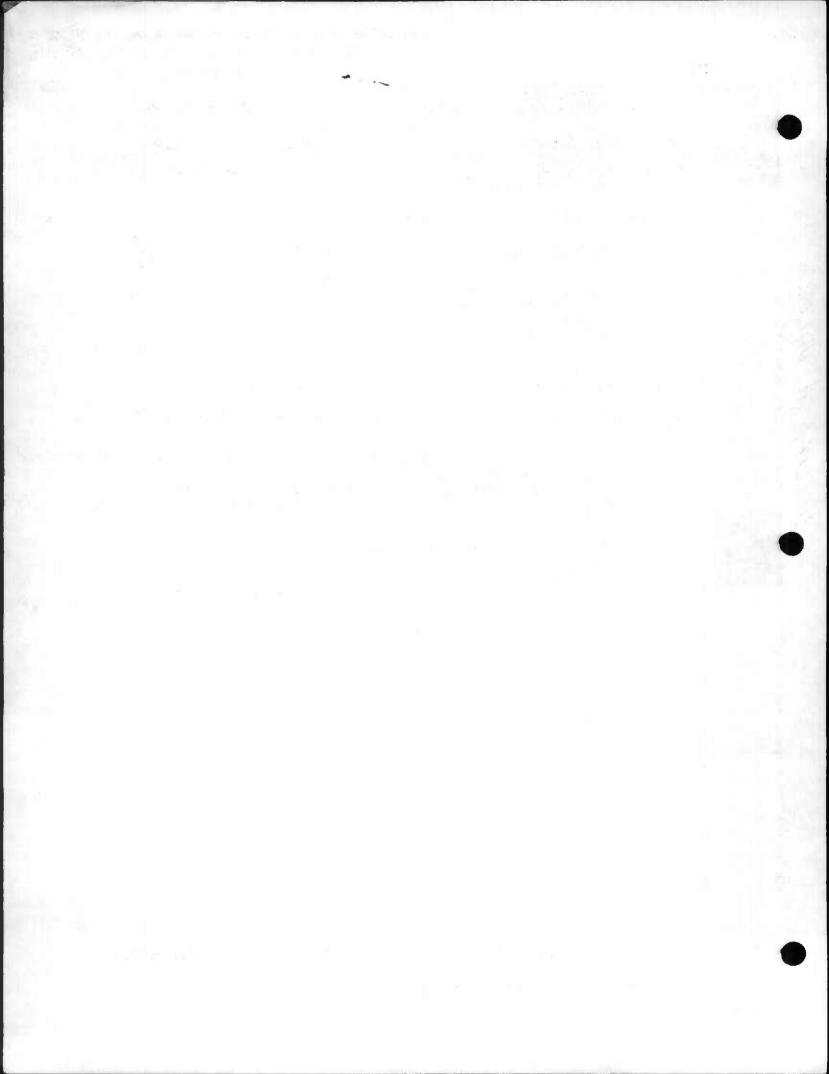


29c. License number

D-46979

29d. Date signed (Month, Day, Year)

January 30,1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** 31 ELEANOR M. NINER JAN. 1999 4:45 AM /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** HOMEWOOD NURSING HOME WILLIAMSPORT WASHINGTON If Undar 1 Yeer If Undar 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (Stata or Foreign Country) WES'T VIRGINIA **Funeral** Months 1 □ M 2 Ĭ F OCT. Director 232-32-5160 94 19,1904 WEST Usual Rasidance of Dacedant 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits id other than "natural", or items 23a or 28a-f ahow svent, the Medical Examiner must be notified at 1 Yas 2 No Director MD WASHINGTON WILLIAMSPORT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16505 VIRGINIA AVENUE 21795 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Ricen, etc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2 No If Yas, Give 1 Navar Marriad 2 Married 1 ☐ Yes 2 No Specify: Specify: þ 34 Widowed 4 Divorced WHITE Yeer or Dates: Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any Injury or other traumatic event, use Me Elamantary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 17. Father's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumame) Be WILLIAM ZILER ELLA HALEY 19a. informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) LOIS STARLIPER/DAUGHTER 21601 O'TOOLE DRIVE, HAGERSTOWN, MD 20b. Plece of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 XBurial 2 ☐ Cremetion 3 ☐ Ramoval from State PLEASANT VIEW MEM. GARD. 2-3-99 MARTINSBURG, WV 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name end Address of Fecility 21. Signatura of Funaral Service Licensae BROWN FUNERAL HOME, PO BOX 821, 327 W. KING STREET, MARTINSBURG, WV 25402 12Kacer 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximeta Intervel Batween Onset and Death **Physician** /Medical Immediata Causa (Finel ONE MONTH diseesa or condition rasulting in daath) Examiner to (or as a consequance of): f Examiner EREPROPRICECIAN Sequantially list conditions, if any, laading to immediata causa. Enter Underlying Cause (Disease or Injury that initiated avants rasulting in daath) Last physician Physician/Medical 2 Due to (or es e consequança of) 如 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 | Yes 2 | No 3 | Probably 4€ Unknown ð 24b. Were eutopsy findings aveileble prior to completion of ceuse of death? Completed 24a. Was an autopsy Pass page 2 2 1 Ne 1 ☐ Yas 1 □ Yes 2 □ No. certificate Be 25. Was casa refarred to medical 26. Placa of Death (Check only one) axaminar? Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this. 28a. Deta of Injury (Month, Day Year) 27. Mannar of Death 28c. Injury at Work? 28b. Tima of 28d. Dascribe how Injury occurred Certification: After Attending 5 Pending invastigation 1 Matural 1 Yas 2 No 2 Accident 8 Could not be determined 3 Sulcida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Placa of Injury - At home, farm, streat, factory, office building, atc. (Specify) atter 4 Homicide 6 To the Hospital within 24 hours a To the Funeral I Medical 1 Certifying Physician: To tha best of my knowledge, daeth occurred at tha time, dete end piece, and due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the best of axamination and/or invastigation, in my opinion, death occurred at the time, data and piace, and due to the cause(s) and menner stated. 29a. Cartifia: (Check only 29b. Signature 29c. Liceosa number 29d. Deta signed (Mogfith, Day, Year)

Macause of deeth (Item 23a) (Type, Print)

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32. Registrar's Signetura

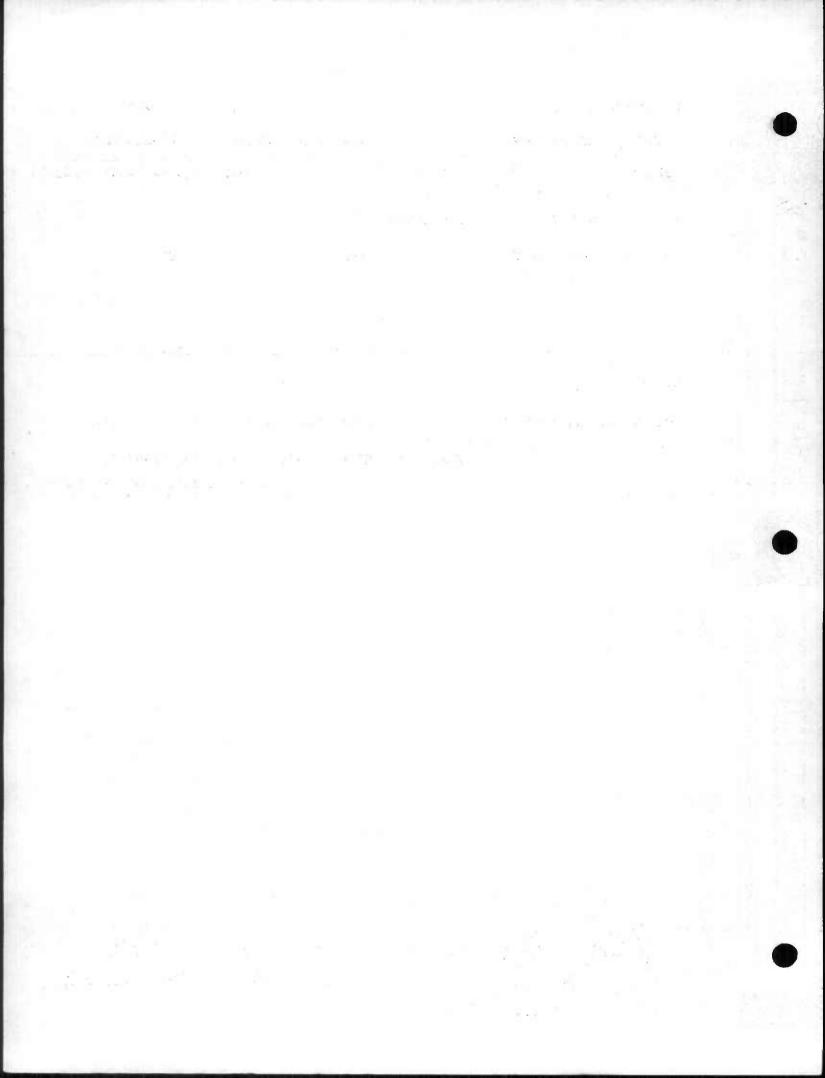
State Registrar 31. Date filed (Month, Day, Year)

FEB

6 1999

Division

Maryland 21215-0020



Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r 21767 USA 14024 Village Mill Drive Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ဩ No If Yas, Giva Yaar or Datas: 11. Meritei Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. Hygiene. other then "neturel", or lien ent, the Medical Examiner. 1 Nevar Marriad 2 N Married 21215-0020 1 Yas 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementary/Secondery (0-12) Collega (1-4or 5+) repair worker Hagerstown Shoe Maryland 17. Fathar's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumama) permit. Pages 1 and 2 should be fitted. Department of Health and Mental: Hy Important: If from 27 is merked other any injury or other traumatic event Be Samuel LaFollette Hall, Sr. Molly Melissa Loudenslager 19a. Informant's Neme/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Betty L. Reedy Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other plece) Deta 1 ⊠ Burial 2 □ Crametion 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funaral Service Licensee 22. Nama and Addrass of Facility Gerald N. Minnich Funeral Home 23a. Pert1. Entar the disease, or complications thet caused the death. Do not antar the mode of dying, such es cerdiec or respiratory arrest, shock, or heart tailure. List only one cause on each line. Physician /Medical Immediata Cause (Final moumous disaasa or condition rasulting in daath) Examiner Julmonenz emsoli Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indisted events resulting in death) Last Records, P.O. Box 68760 Dua to (or es e consequence of): Part II. Other significant conditions contributing to death but not rasulting in the underlying causa given in Part I. MBROSIS 24a. Was en autopsy performed? Completed Newkirk, Grace

1. Decedent's Name (First, Middla, Last)

5. Social Security Number

214-09-5566

10a. Stata

Maryland

Usuel Residence of Decedent

25. Was case referred to medical examiner?

5 Pending invastigation

6 Could not be datermined

FEB 0 9 1999

1 Yes 2 TNo

27. Menner of Death

1 ONetural

2 Accidant

3 ☐ Suicide

4 Homicida

(Check only

29b. Signature and

JOHN REKEN 31. Days filed (Month, Day, Year)

Be

edical

Physician

/Medical

Examiner

Funeral

Director

Grace Irene Newkirk

Washington

Washington County Hospital

1 M 2 F

4e Facility Nama (If not institution, give street and number)

10b. County

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Maugansville

10c. City, Town or Location

State of Maryland / Department of Health and Mental Hygiene 9 9 Certificate of Death

2. Date of Death

Epinord

Month

4b. City, Town, or Location of Death

Hagerstown

7. Aga (In yrs. last birthday) If Under 1 Yaar | If Under 24 Hrs. | 8. Dale of Birth | 9. Birthplaca (State County) | 1. Months | Days | Hours | Min. | November 27, 1910 | Mary Land

3. Time of Death

9. Birthplaca (Stata or Foraign

10d. Inside City Limits 1 ☐ Yas 2 ☐ No

1310

1999

Washington

White

4c. County of Death

8

217 S. Mont Valla Avenue Hagerstown, Maryland 21740 20c. Location - City or Town, Stata Cedar Lawn Memorial Park 2/11/99 | Hagerstown, Maryland 305 N. Potomac Street Hagerstown, Maryland 21740 Approximete interval Batwaan Onsat and Death 2 weeks T MO 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to complation of cause of daath? 1 Yas 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 Propatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 ☐ Yas 2 ☐ No 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To tha best of my knowledge, death occurred at the tima, date and place, and due to the ceuse(s) end menner es stated.

2 Medicat Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the causa(s) and manner stated. 29c. License number 29d. Dala signed (Month, Day, Year) D43590 addrass of person who completed ceusa of death (Item 23a) (Type, Print) Jefferson BLUD SMITHSBURG, MD **ORIGINAL**

Registrar DHMH 16 Rev 6/95

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Division

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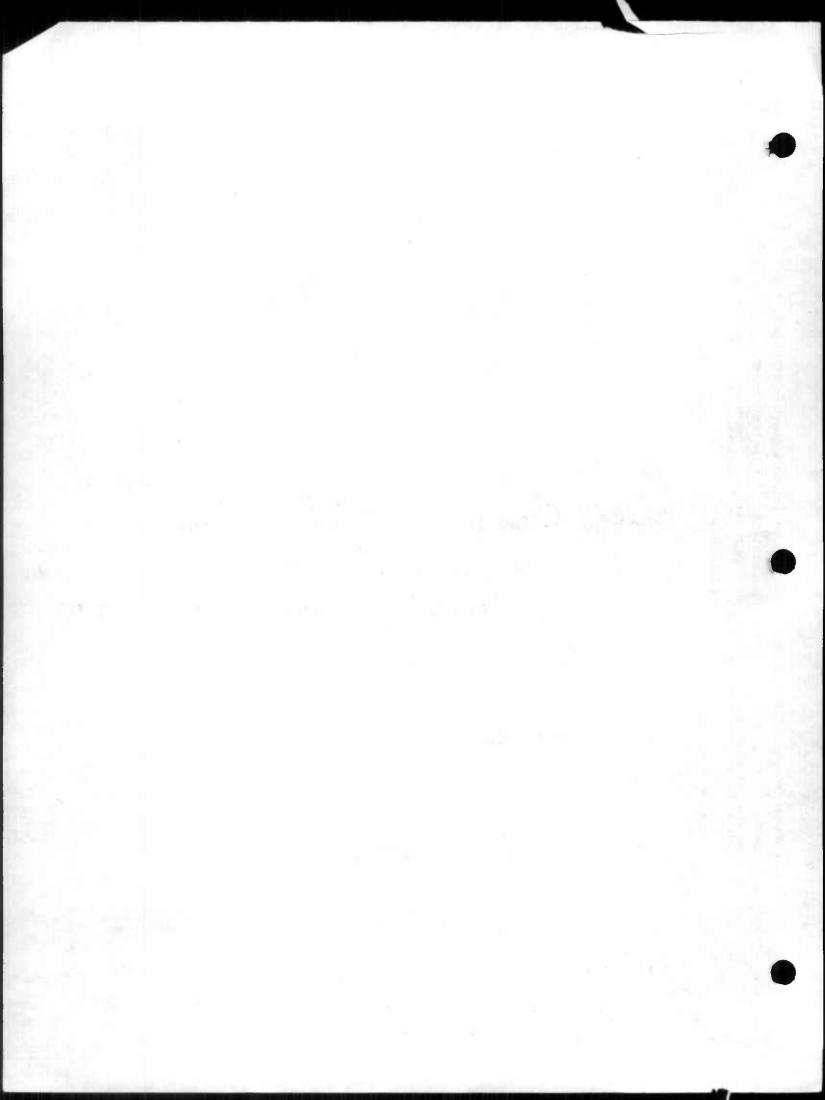
Attar or Attending

Director

within 24 hours To the Funeral

To the

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death Month **Physician** MARY ANN NICK 1940 TEBRUARY /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 K F Yrs. 228-74-7910 49 Director Japan Usual Residence of Decedent the Menylend 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Worcester Ocean City 1DXYes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1G r than "natural", or items 23s or the Medical Examiner must be 21842 USA 7604 Coastal Highway Jada Condo permit. Pages 1 and 2 should be filed within 72 hours efter deeth v Department of Health end Mental Hygiene. Important: If Item 27 Ia marked other than "natural", or Itema 23, any Injury or other traumatic event, the Medical Express Funeral 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) Black, White, etc. 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Datas: 1 Navar Marriad 2 Married 1 Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Instructional Aide School System 12 18. Mothar's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Frieda M. (Unknown) Frank J. Tringali 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 7604 Coastal Hwy. Unit 1G Ocean City, MD 21842 William R. Nick/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremetion 3 Removal from Stata Evergreen Cemetery 2/13/99 Berlin, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Address of Facility Burbage Funeral Home 108 William St. Berlin, MD Approximate Interval Between Onset and Death Part Enty in disease, or complications shock, or heart failure. List only one can at caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Physician Immediate Cause (Final disaase or condition resulting in death) /Medical 30 m Examiner Due to (or as a consequence of): Physician/Medical Examiner (ongeo physician end the buriei-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Due to (or as a conseque nce of): Box 68760, ova Due to (or as a consequence of) for use es signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown A□ Yes 2□ No þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of causa of death? 1□ Yes 20 No 1 Yas 2 No or Attending Physician: efter deeth. Director: After this certifica 25. Wes case referred to medicel examiner?

1 No Be 26. Place of Death (Check only one) To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or A within 24 hours efter To the Funeral Directompletely littled in by 29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner es stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and mannar statad. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licensa number 20050 any 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 11 Registrar

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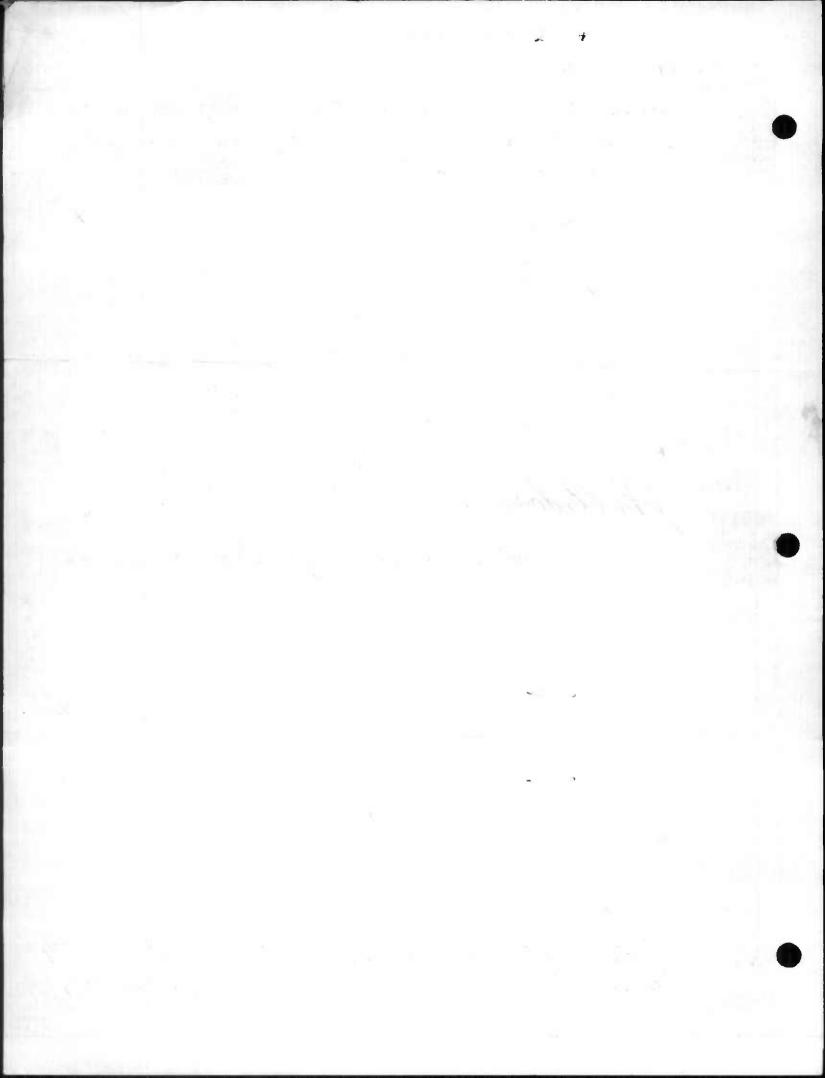
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ITEM: #2, PER PHY G769 3-5-99 WR. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month 9,00 AM Feb 10 OZ JOHN Phillips /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Summit AVB HAGERS HOWN WAShqirton If Under 24 Hrs. 8. Dete of Birth
Hours Min. (Month, Day, Year) 5. Sociel Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days 150M 20 F Yrs. Director 249-82-9931 91 14,1999 High Point NC Usuel Residence of Deceden the Marylend 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examiner mast be notified at 1 Yes 2 No Director SC Cherokee Gaffney 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? death with 1608 Bonner Road 29341 Funeral U.S.A. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 Never Merried Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: White þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 end 2 should be flied within 7. Department of Health end Menlel Hyglene. Important: if Item 27 is merked other than "na any Injury or other traumatic event, The Medic once. Elementery/Secondary (0-12) College (1-4or 5+) Truck Driver Long distance Transport 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Willie H. Phillips Millie Hayes 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Patsy Phillips -Wife 1608 Bonner Rd, Gaffney SC 29341 20b. Place of Disposition (Name of cemetery, cremetory or other place)
Crestview Baptist 20c. Location - City or Town, Stete 20a. Method of Disposition Date 1 ■ Burial 2 □ Cremetion 3 □ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Church Cemetery
22. Name end Address of Fecility 2-14-99 Gaffney, SC Hunter-Anderson Funeral Home 106 S. Mercer St. Berkeley Springs WV 25411 Inter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on each line. Approximete Interval Between Onset end Death **Physician** /Medicai Immediate Ceuse (Final diseese or condition resulting in death) onday UNTULAR Examiner Due to (or es e consequence of): Examiner physician and the burief-trensit that the death certificate be executed Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or as e consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown signed b Division of Vital Records. by 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed hes page ; 1 Yes 2 No 1 Yes 2 No certificate director, 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospital: 1 Se 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) To 1 Inpatient 2 ER/Outpatient 3 DOA this After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pi within 24 hours efter death. To the Funeral Director: After the completely filled in by the funera Certification: 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturel 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Exeminer: On the bests of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of cartified 29d. Date signed (Month, Day, Year) end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 818 Vã HAQUISTOR UIRGWA HORN 31. Date filed (Month, Day, 32. Registrar's Signeture State FEB Registrar 1999

DHMH 16 Rev 6/95

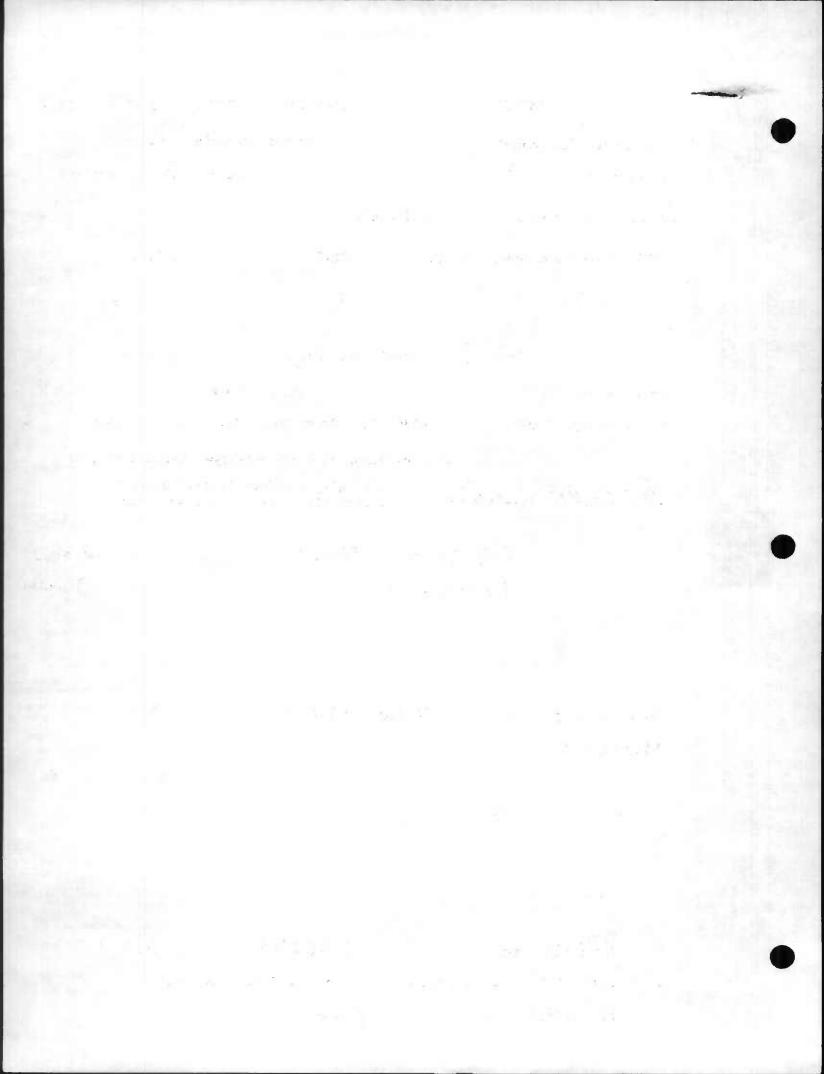
SEA -



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Ammended # 6,St. Mary's, 2/9/99, D1b 1. Decedant's Nama (First, Middle, Last) 2. Data of Daath 3. Tima of Death FEBRUARY Physician MARY 1,1999 RICHARDSON 1805 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva straat and number) 4c. County of Death Examiner Prince Frederick Calvert Calvert Memorial Hospital If Undar 1 Year | If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 5. Social Sacurity Number 6. Sax 8. Data of Birth (Month, Dev. Year) Birthplaca (Stata or Foraign Country) **Funeral** 1□M 2\ F Months Days Hours Min 81 XXX Yrs. Director 578-26-7883 July 26,1917 Maryland Usual Rasidance of Decedant permit. Peges 1 end 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Event must be notified at once. 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2X No Maryland St. Mary's California Directo 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 23140 Cobblestone Lane, Apt 203 20619 U.S.A. Funerai 12. Was Decadant Evar in U,S. Armad Forcas? 1 ☐ Yas 2 ∑ No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Race - American Indian. Black, Whita, atc. 1 Navar Married 20X Married 1 Yas 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decadant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 2yrs Registered Nurse Hospital 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be James Joseph Kirk Clara Habig 19e. Informent's Name/Reletionship (Type, Print) 19b. Malling Addrass (Street end Number or Rurel Routa Number, City or Town, Stete, Zip Code) 45341 Nats Creek ROad, Hollywood, MD 20636 Denise M. Rekemeyer/Daughter 20b. Place of Disposition (Nama of cematery, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 X Buriai 2 ☐ Cramation 3 ☐ Ramoval from Stata Charles Memorial Gardens 2/5/99 Leonardtown, MD 4 ☐ Donation 5 ☐ Other (Spacify) 21. Signalara of Funaral Sarvica Lican 22. Nama and Addrass of Facility Mattingley-Gardiner Funeral Home, P.A. ichae redener P.O.Box 270, Leonardtown, MD 20650 23a. Part1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haert feilure. List only one ceuse on each line. Approximata Intervel Between Onsat and Daath **Physician** Immediata Causa (Final disaese or condition rasulting in death) /Medical RESPIRATORY Examiner Physician/Medical Examiner PNUEMONIA attending physician end for use as the bunal-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata ceuse. Enter Underlying Ceuse (Disease or Injury that initiated avants Division of Vital Records, P.O. Box 68760, Dua to (or as a consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown COWJOLI DATION WITH PNUEMONIA þ 24b. Wara autopsy findings availabla prior to complation of ceusa of daath? 24a. Was an autopsy performad? Completed BEMENNA has e 2 is certificate ha 20 No 1 Yas 2 No 1 Yas i or Attending Physician: efter death. 25. Was cesa referred to medical axaminar? Be 26. Placa of Death (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No npatiant 2 ER/Outpatient 3 DOA Certification: To After this 27. Mannar of Death 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding invastigation 1 Natural 1 Yas 2 No 2 Accidant Director: / 6 Could not ba datamined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straet, factory, office building, atc. (Specify) 4 Homleide To the Hospital of within 24 hours of To the Funeral D completely filled in Certifying Phyelcian: To the best of my knowledga, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar es steted.

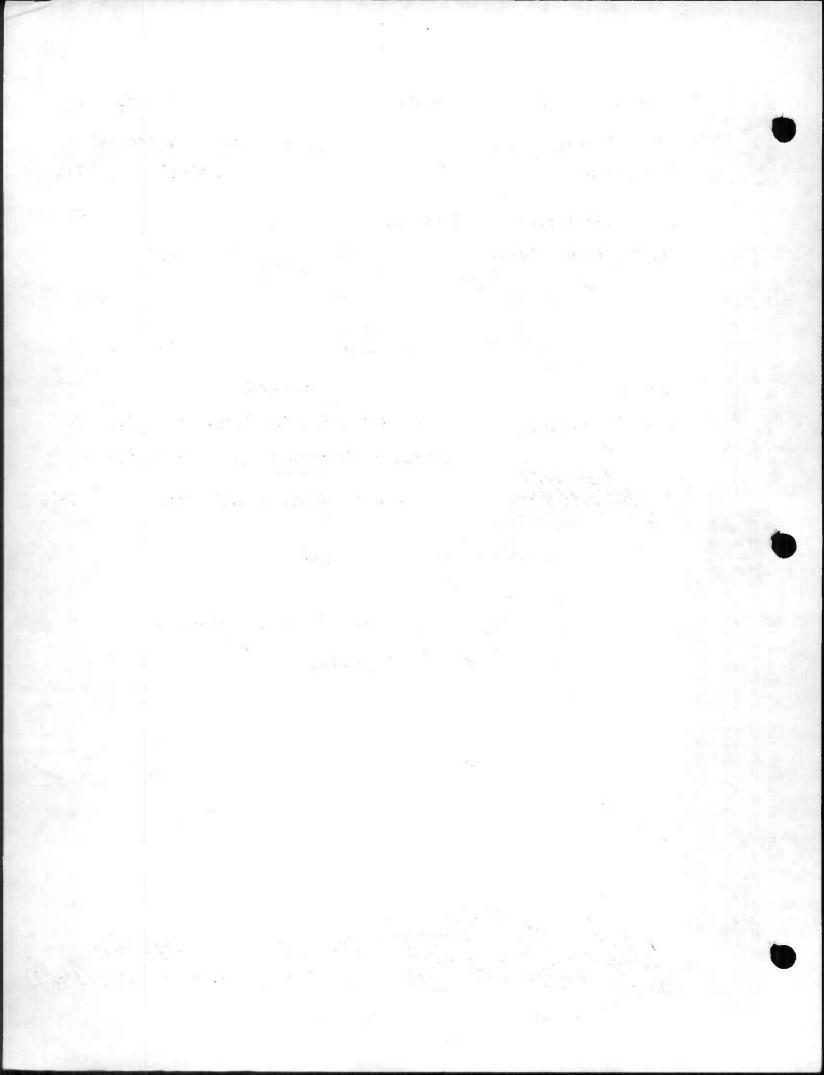
| Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, dete and place, end due to the cause(s) end menner stated. 29a. Cartifiar Medical (Check only one) 29b. Signatura and titla of cartifiar 29c. Licansa numbar 29d. Data signed (Month, Day, Year) am 30. Neme and eddress of parson who completed ceuse of death (Item 23e) (Type, Print) Dr. P. Patel M.D. 100 Hospital Rd., Prince Frederick, Md 20678 31. Data filed (Month, Dey, Year) 32. Registrar's Signatura State bouch FEB 8 1999 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 05045 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month 2 99 **Physician** CHARLES RODGERS 0615 6 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** OCEAN (If Under 24 Hrs. 509 C PENGUIN DRIVE CITY WORCESTER Birthplece (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) 10-30-08 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours Min. 10M 20F Months Deys 90 Yrs. 213-05-9183 MD. Director Usual Residence of Decedent the Marylend 10d. fnside City Limits 10e. Stete 10c. City, Town or Location 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Yes 2 No Director Mo. WORCESTER OCEAN CITY 10e. Street end Number 10f. Zip Code 10g Citizen of What Country? with 21842 509 C PENGUIN U.S.A. DRIVE Funeral death 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 12. Was Decedent Ever In U,S. Armed Forces? 1 Yes 2 No If Yes, Give 11. Meritel Stetus filed within 72 hours after 1 Never Married 2 Married 1 Yes 20 No Baltimore, Maryland 21215-0020 Specify: Specify: WHITE by 3 Widowed 4 Divorced Year or Detes Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) TRANSIT MOTORMAN 17 Father's Name (First Middle Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 UNKNOWN 2 UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Health am 27 I OCEAN CITY, MD. 21842 509 C PENGUIN DR. A. RODGERS JEAN. Department of Heal Important: If Item 2 any Injury or other 20b. Plece of Disposition (Name of cemetery, crematory or other piece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 □ Buriel 2 ☑ Cremetion 3 □ Removal from State SALISBURY CREMATORY 2-6 SALSBURY, MD. 5 Other (Specify) 21. Signature of Furnital 22. Name end Address of Fecility ULLRICH FUNERAL HOME BERLIN, MD. 21811 Ther the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner physician end the buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Division of Vital Records, P.O. Box 68760, Physician/Medicai 88 USB I o signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Probably 4 Unknown 1 Yes 2 No by 24b. Were autopsy findings eveileble prior to 24e. Wes en eutopsy Completed completion of cause of death? page 2 s 1 Yes 20 No 2 100 1 Yes certificata or Attending Physician: director 25. Was case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 51 Aesidence 6 Other (Specify) 1 Yes 2 No Lo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral Certification: 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending aftar death. Director: Aft 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) filled in by 4 ☐ Homicide 24 hours a Funeral D Hospital 29a. Certifier 1 Cartifying Phyalcian: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. Medical completaly (Check only 2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the 1 29b. Signature and til 29c. License number 29d. Date signed (Month, Day, Year) (Type, Print) FIEB 08 32. Registrar's Signeture State 1999

DHMH 16 Rav 6/95

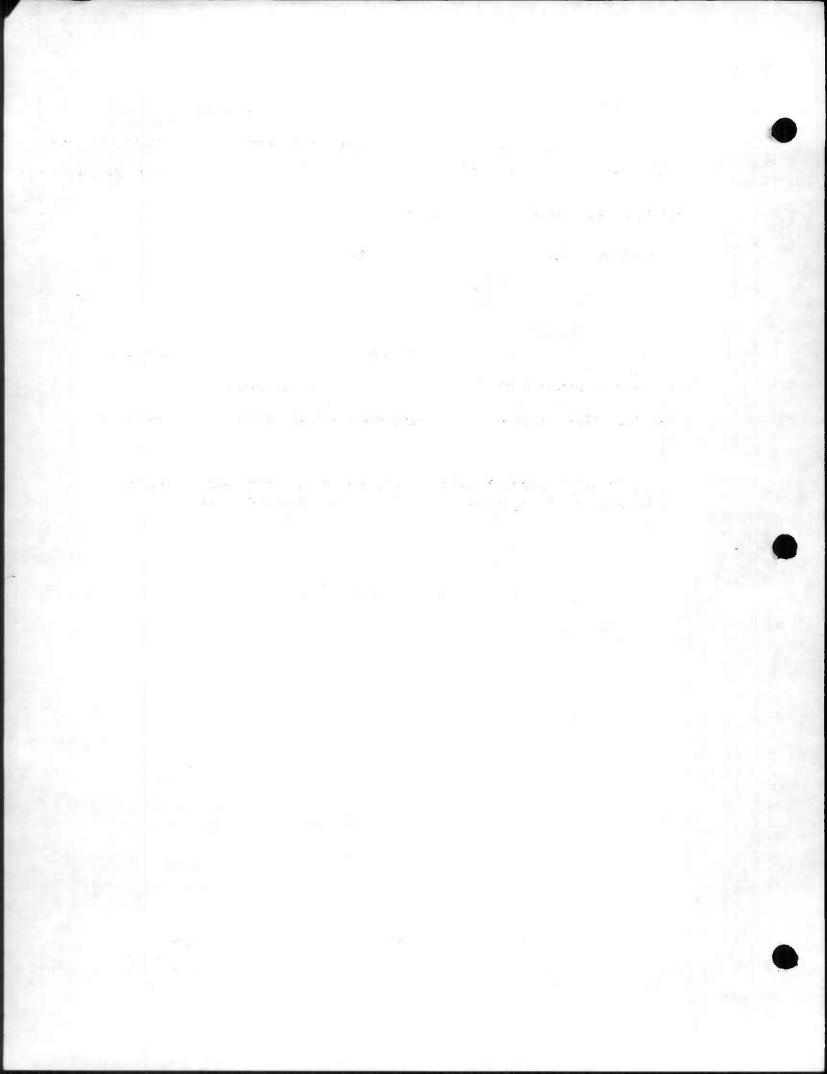
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene 768 2-18-99 rja Certificate of Death Reg. No.

1/ Per A	.B. Film G768 2-18-99	rja	Co	ertificate of	Death		Reg. No.		3. Time of Deeth			
hysician /Medical	Decedent's Name (First, Middle, La VERA	st)	RILEY			2. Dete of Dee Month	Day Day	Yeer 1999	1:55 PM			
xaminer ineral	4e Facility Neme (If not institution, giv 0HNS HOPKINS (5. Social Security Number 236-48-9441	BAYVIEWI	UPDICAL (In yrs. lest birthde 6 Yrs.	(CUTER y) If Under 1 Year Months Deys	4b. City, Town, or Lo Baltimore if Under 24 Hrs. Hours Min.	8. Dete of Birt (Month, De)	Balt	imore 9. Birthpla	e City ace (State or Foreign y) t Virgini			
nd at	Usuel Residence of Decedent		10a Ohr Taur at	Location				1				
or or	Maryland Baltimo	re	10c. City, Town or Dundalk	Location				10	d. Inside City Limits 1 ☐ Yes 2 ☑ No			
rect	10e. Street end Number			10f. Zip Code			10g. Citizen of W	/het Counti	ry?			
ō	8106 Bletzer Road	i		21222			U.S.A.					
by Funeral Director	11. Maritel Status 1 ☐ Never Merried 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Detes:		I. Was Decedent of I If Yes, specify Cub	Hispenic Origin? (Spenan, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Rece Blec Specify	e - America k, White, e : Wh				
Completed	15. Decedent's E. (Specify only highest green Elementery/Secondary (0-12)	ducation ide completed) College (1-4or 5-	16e. Dec	edent's Usuel Occur re kind of work done DO NOT use retire	pation during most of work ad)	ing	16b. Kind of Bu	siness/Indu	ustry			
	12	0		nemaker			Own 1	Home				
To Be (17. Father's Neme (First, Middle, Last) Ernest Ernest L. Lypol	4 11 1 4			18. Mother's Name Wilma Ha		Maiden Sumem	e)				
	19e. Informent's Name/Reletionship (Maurice Riley/h				ral Route Number, City or Town, Stete, Zip Code)							
	20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specif	y)	20b. Plece of Dis cemetery, co	position (Neme of rematory or other ple	ece)	Date	20c. Location -	City or Tov	vn, State			
once.	21. Signature of Enteral Service Licenses and Prince State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201											
n al	23e. Perft. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Finel disease or condition	plicetions that caused one ceuse on each line		inter the mode of dy	ing, such es cardiec (or respiretory er	rrest,		Approximate Interval Between Onset and Death			
er	resulting in death)	a	Due to (or es e cons	equence of):				1	1 19 19 11			
edicai Examiner	Sequentially list conditions, if any, leeding to immediate	U.	HOLIC (Or es e cons	CIRRHOS equenca of):	SÍS			1/0	YEARS			
by Physician/M	Part II. Other significant conditions of			the cause of death								
Completed b							en eutopsy rmed?	eve com of d	re eutopsy tindings illeble prior to npietion of cause leeth?			
Be	25. Wes case referred to medical				26. Piece of Deet	n (Check only o			7100 20110			
To E	examiner? 1 Ø Yes 2 □ No	Hospitel: 1 Inpatier	nt 2 ER/Outpat	ient 3 DOA	ther: 4 Nursing Ho	me 5 Resid	dence 6 Oth	er (Specify)			
	27. Manner of Deeth 1 Neturel 5 Pending investigation		Year) 28b. Time injury	We	ork?] Yes 2 □ No	28d. Describe I	how injury occurr	red				
Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homloide determined	28e. Pleca of inju building, etc.	ry - At home, ferm, (Specify)	street, fectory, office		28f. Location (S City or Tox	Street end Numb vn, State)	er or Rurel	Poute Number,			
edicai	29e. Certifier 1 Certifying Ph (Check only one) 2 Medical Example	ysician: To the best of niner: On the basis of end manner stat	examination end/or	eth occurred at the t investigation, in my	ime, date end plece, opinion, deeth occurr	end due to the ed et the time,	ceuse(s) and ma date end pleca,	inner as ste and due to	ated. the cause(s)			
2	29b. Signature end title of certifier 30. Name end eddress of person who Samun thas Samun thas Samun than Samun than Share S	W		29c. Licen	se number		29d. Date signed	d (Month, E	Dey, Year)			
	30. Name end eddress of person who	completed cause of de	eth (Item 23e) (Typ	e, Print) JOH N	IS ADPKINS	SBAYV	IEW ME	DICAC	CENTER			

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death Day Month **Physician** 9, Barbara Sciler 1999 February 5:30 PM /Medical 4b. City, Town, or Location of Daath 4a Facility Nama (If not institution, giva straat and number) 4c. County of Death Examiner Bayside Nursing Center Lexington Park St. Mary's If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Yaar) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** 1 □ M 2 ■ F 63 Yrs 218-34-7255 February 4,1936 Washington, DC Director Usual Rasidance of Decedant with the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ■ No Directo St. Mary's Maryland Park Hall 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Coda 20075 Manor Drive 20667 United States permit. Pages 1 and 2 should be filed within 72 hours after death. Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event. the Medical Funeral 14. Race - American Indian 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 11. Marital Status Black, Whita, atc. 1 ☐ Yas 2 ■ No If Yas, Giva Yaar or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yas 2 ■ No Spacify: Specify: þ White 3 ☐ Widowed 4 ■ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Spacify only highest grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Manager Mote1 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Edward L. Marr Isabelle Maloney 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 20075 Manor Drive, Park Hall, Maryland 20667 Barbara Knott, Daughter 20b. Place of Disposition (Nama of cemetary, cramatory or other place) Data 20c. Location - City or Town, State 20a. Mathod of Disposition 1 ☐ Burial 2 ■ Cramation 3 ☐ Ramoval from State 2-11-99 Alexandria, Virginia 4 ☐ Donation 5 ☐ Othar (Specify) Metropolitan Crematory 21. Signature of Funaral Sarvice Licensas 22. Nama and Addrass of Facility Brinsfield Funeral Home, P.A. Korald L. Thompson M01154 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Daath **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Cell Utterine **Examiner** Dua to (or as a consequence of) Examiner that the death certificate be executed physician and the burial-tran Sequantially list conditions, if any, laading to immadiato causa. Enter Underlying Causa (Disaasa or injury that initiated avents rasulting in daath) Last Dua to (or as a consequence of): Physician/Medical Due to (or as a consequence of): esn signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 40 Whown by 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? certificata hes or Attending Physician: effer death. Director: After this certifica funeral director, 25. Was casa rafarrad to medical axaminar? Be 26. Placa of Daath (Check only ona) Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 0 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Daati 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred Certification: 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 Could not be 3 ☐ Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 4 Homicida Hospital edical Confliging Physician: To the bast of my knowledga, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 29a. Cartifian (Check only one) 2 Medical Examination in the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. Within 2 To the 29b. Signature and title of 5 29c. Licansa number 29d. Dafa signed (Month, Day, Year)

State Registrar

FEB 1 1 1999

Boyd,

Mame and add

31. Data filed (Month, Day, Year)

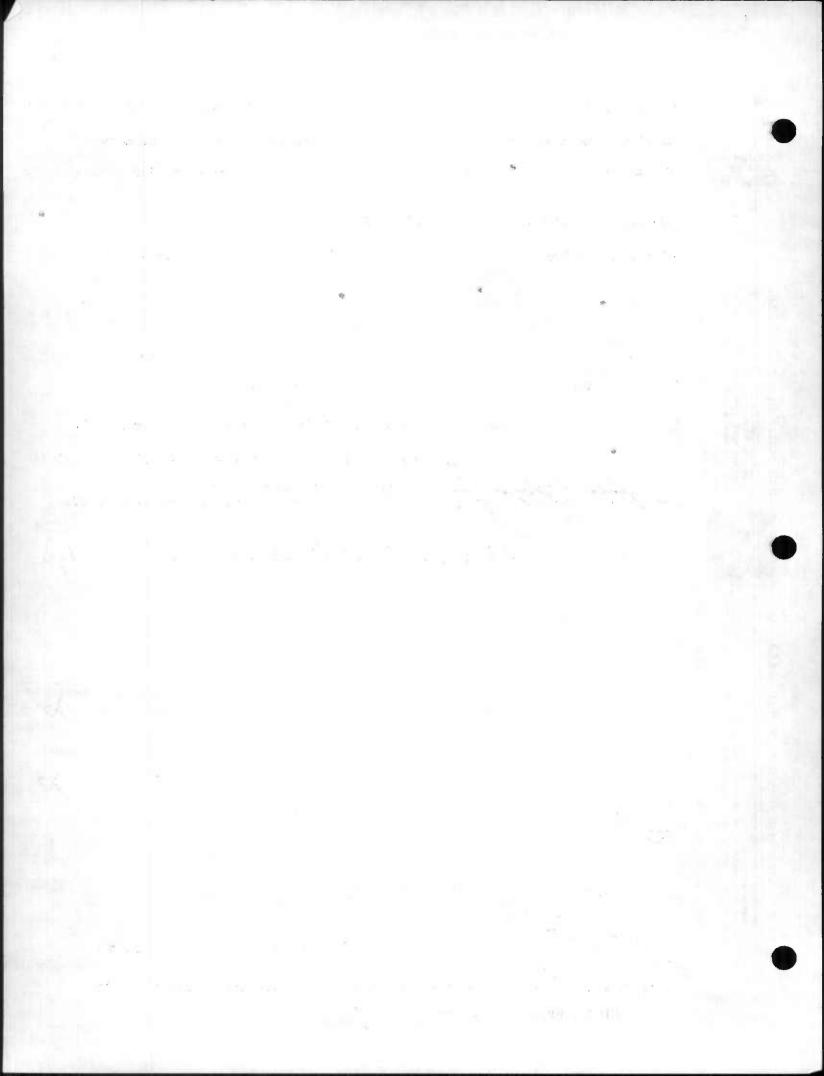
James

2050 Wildewood Court, California, Maryland 20619 32. Registrar's Signatura

person who complated cause of death (Itam 23a) (Type, Print)

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



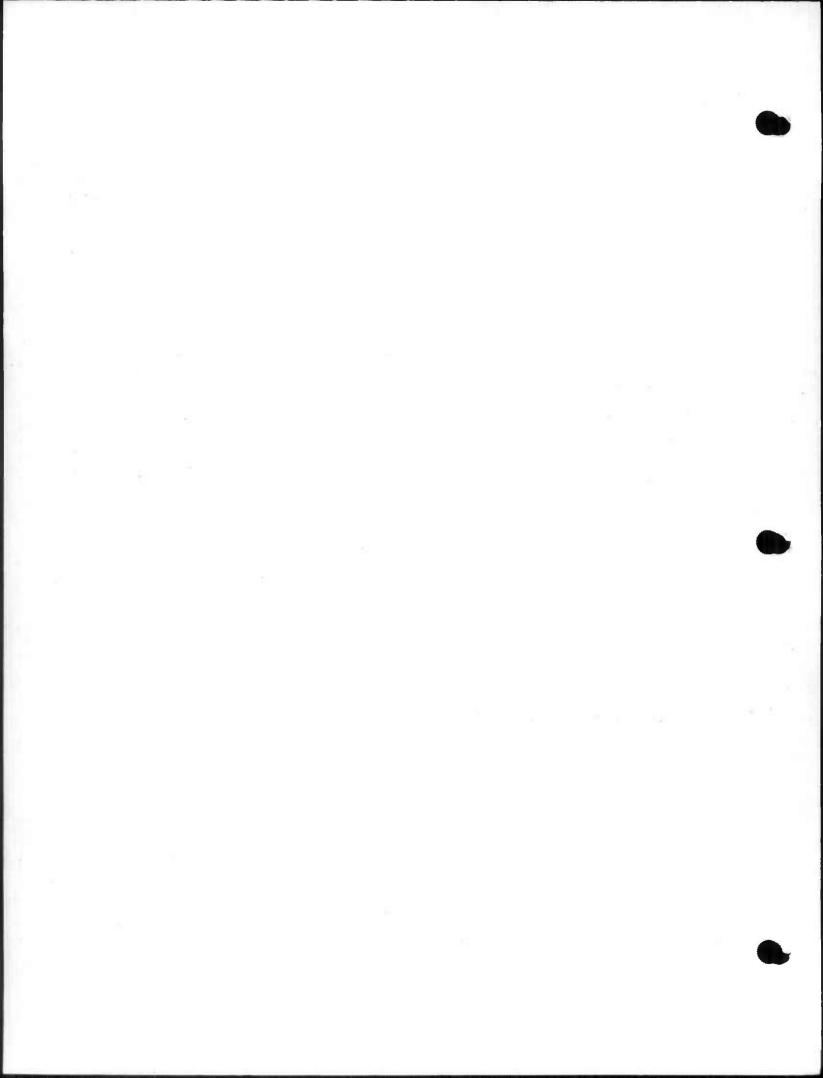
BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and feath. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

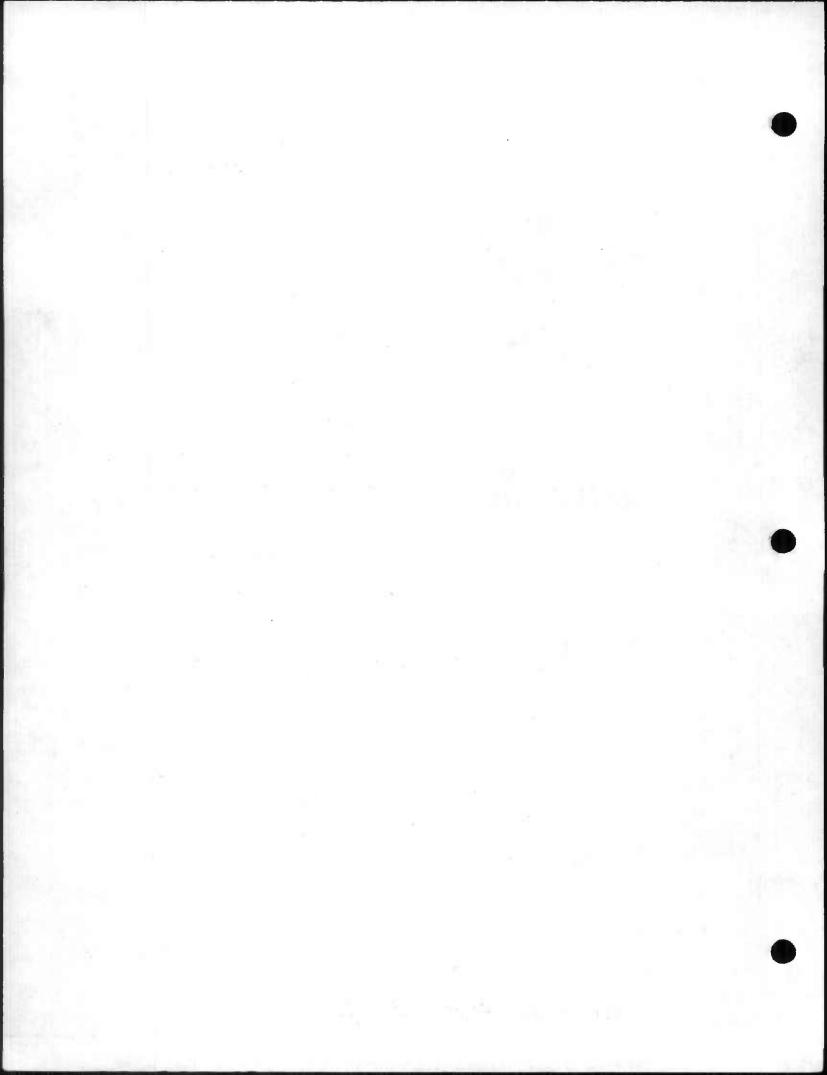
	REGISTRAN		C	CHIIF	ICALE	L UF	DEA	111	F	IEG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF	DEATH			3. TIME OF DEATH
	Sarah Jane SOUDE	ERS							Feb.	8	1999	YEAR	90 4
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. Is	ast hirthday)	IF UNDER	1 YEAR	IF UNDER	24 MDS	7. DATE OF		1999		IPLACE (State or Foreign
	017 00 6040	1 M 2 X F		YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, De	y. Year)		Count	(Y)
	217-28-6843	**	98	ino.							nnsylvania		
	9e. FACILITY NAME (If not institution, give s	street and number)			9b. CITY	, TOWN	OR LOCATI	ON OF DE	ATN		9c. COU	NTY OF C	EATH
6	1052 Corbett Sti	reet			H	age	rstow	m			Was	hing	ton
ರ	RESIDENCE OF DECEDENT												
DIRECTOR	10e. STATE 10b. COUNT	10c. CIT	Y, TOWN C	R LOCA	TION						tod. INSIDE CITY LIMITS?		
ā	Maryland Wast	nington		На	gers	town	n						t X YES 2 NO
7	10e. STREET AND NUMBER				0	7	f. ZIP COD	E			10a, CITI	IZEN OF V	WHAT COUNTRY?
FUNERAL	1052 Carbott Cta					-	217	14.0			22 (1)		310000
뿔	1052 Corbett Sti											S.A.	
5	1 Never Married 2 Merried	T EVER IN U.S. A	NO NO	13.	WAS DEC	CENDENT Cook	OF HISPAN In, Mexice	HC ORIGIN? (S	pecify Yes	or No-	14. RACI	E — American Indian, k, White, etc.	
ВУ	3 X Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES		1	YES	2 X NO	Specify	/:	, , , ,		Spec	My:
	Xcome 4 Divorces	l											White
COMPLETED	t5. DECEDENT'S EDU (Specify only highest grade	CATION completed)	18e, D	ECEDENT'S	USUAL O	CCUPATION OF	ON net of wordsir	200	16b. KIN	D OF BUS	INESS/INE	DUSTRY	
Щ. I	Elementary/Secondary (0-12)	College (1-4 or 5 +	ì	Give kind of v e. Do NOT us	is retired.)	Juny III	OSE OF WORK	9					
립	12	0		omema	ker				Не	er ow	n ho	me	
8	17. FATHER'S NAME (First, Middle, Last)			Cindina	1001		10 MOT	MED'C NA	ME (First, Middl			mo	
						and the second		ca Per					
BE	Harry Crunkletor					1							
2	19e. INFORMANT'S NAME (Type/Print)							Route Number, (
-	Charles W. Soude		13437	C1o	ppe:	r Roa	ad I	lagersi	lown,	Md.	217	42	
	200, METNOD OF DISPOSITION		20b.PLACE	AND DATE	OF DISPOS	ITION /N	ame of		OATE	20c. LOC	ATION —	City or To	wn. State
	1 X Buriel 2 Cremetion 3 Rem 4 Donation 5 Other (Specify)	oval from State	Rost	Have	ther place)	mete	2737	2/	12/99				Maryland
- 1	21. SIGNATURE OF FUNERAL SERVICE LIC	PENSEE	Rest	nave			ND ADDRE						
- 69	94	m	7		/ "	NAME A	ND ADDRE	SS UP FAI	Mi	nnic	h Fu	nera	1 Home
	- CACI	1////	man	che	7 4	15	E. Wi	llsor	Blvd.	На	gers	towr	, Md. 21740
	23. PART I. Enter the diseeses, or	complications that	caused the d	eeth Do s	_						_		
	shock, or heart failure.	List only one ceu	se on each lin	e.	iot enter	tire tire	oue or uy	my, suc	n es ceraiec	or respir	atory an	rest,	Approximate intervel Between
	IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. Conget (10 e heart failure weeks) Due to (or as a consequence of):												
	disease or condition resulting in death)	· Con	1001	ive	ho	2 u7	-6	2 54	11000				weaks
	resolding in death)	DUE TO	OR AS A CONSE	EQUENCE OF	F):	V	- 1 4	24.			-		
_ 1	_	D:/	OR AS A CONSE	1 0	ainal	150	ma	2 mi	The				200 - +/.
6	Sequentially list conditions,	b. Due To	OR AS A CONS	COLLENCE OF		-00	7	ofo	eng				morths
CERTIFICATION	if any, leeding to immediate cause. Enter UNDERLYING	カー	ent	.GOENCE OF).	. 0	~/	8	AGUE	1300	-		2 months
0	CAUSE (Disease or Injury	e Rec	eni	mayo	OCA	val	cal	16	16 ore	1100	^		ZMOUN
ᄩᅵ	that initieted events	OUE TO	OR AS A CONSE	OUENCE/OF	F):								
	resulting in deeth) LAST	d											
EDICAL	PART II. Other significent condition	s contributing to	death but not	recuiting i	n the un	derlyin	g ceuse	given in	Part I. 24	PERFORI		24b	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
호										YES 2		1	COMPLETION OF CAUSE
									— I.,		W NO		OF OEATN?
Σ									— J			į	1 TYES 2 NO
Z I	DID TOBACCO USE	CONTRIBUTE	E TO CAL	JSE OF	DEA	TH '	YES [] NO					
ᇹ	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:					LACE OF D	EATH (Che	ack only one)				
S	t TYES 2 NO	1 Inputient 2	ER/Outpatient	3 DOA	OTHER		ne 5 Re	sidence	8 Other (Sp	ec/fv)			
PHYSICIAN:	27. MANNER OF DEATN	28e. DATE OF		28b. TIM	E OF	28c. IN.	JURY AT		28d. DESCRI		JURY OC	CUREO	
	t Natural 5 Pending	(Month, De	ny. Year)	INJ	URY	WC	YES 2	٦ ١١٥					1
B	2 Accident Investigation							NO					
ا ۵	3 Suicide 8 Could not be	28e. PLACE Of building,	F INJURY At h etc. (Specify)	ome, ferm, s	street, tect	ory, offic	ie .		281. LOCATIO City or To	N (Street ei wn, State)	nd Number	or Rural I	Route Number,
	4 Nomicide determined								,	,			
	290. CERTIFIER	CIAN: To the heat of	en benudada a	- ath	4 - 4 - 10 - 10						III E E E E		
COMPLET		ICIAN: To the beet of											
٥ ا	One) 2 MEDICAL EXAMINE	H: On the beele of ex	emination end/or	Investigatio	n, In my o	pinion, o	death occur	red at the	time, date end	place, end	due to th	ne ceuse(e	end menner ee stated.
	29b. SIGNATURE AND TITLE OF CLATTERE	1//					29c. LICI	ENSE NUN	IBER		29d. DAT	E SIGNED	(Month, Day, Year)
BE	181.0.01	Louis	en	mS	2		D	111	33	ļ	DE	- /	10 10-
2	30. NAME AND ADDRESS OF PERSON W	O COMPLETED CALLS	E OF OFATH AT	EM 27) 75-	Orint)		1				. 6	n/	011771-
	Phasele PC	O SOMPLETED CAUS	// A AA	IN 21) (NPe,	rant)		12.	11	-		1.2		
	crusis e- spen	cer III	10 Me.	dital (amp	45	Kol	Has	gers 6	wa	MU	21	142
	31. DATE FILEO (Month, Day, Year)		R'S SIGNATURE	P	-	-		1					
	FEB 1 1 19	199 🔎	The state of the state of	Ø.	A.	000	1/2/						142
_					1-5	14							



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			Ce	rtificate d	of Death	7		Reg. No.					
Dhusisian	1. Decedent'e Neme (First, Middle, Last						2. Date of De Month	eath Dey	Year	3. Time of Deeth			
Physician Medical	Lester Guy	Stouffer					7 /		999	13:35			
Examiner	4e Facility Neme (If not institution, give Washington (· ·	pital			own, or Lo	ocation of Deat			igton			
Funeral Director	5. Social Security Number 214-09-0587 6. Se	× 7. Age (In)	rs. last birthday) Yrs.	If Under 1 Ye Months De		Min.	8. Date of Bi (Month, Di December	18,1912		ace (Stete or Foreig Pland			
2	Usual Residence of Decedent												
with the Meryland a or 28a-f ahow the notified at	Maryland Washing		City, Town or Li Hager						10	od. tnside City Limits 1 Yes 2 □ No			
leath with the Meryle na 23e or 28e-f aho must be notified at eral Director	10e. Street and Number 517 Frederic	ck Street		10f. Zip Coo	1740			10g. Citizen of V USA		ry?			
urs after d ar, or hen seminar	11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in Amged Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:		Was Decedent If Yes, specify (1 ☐ Yes 2 ☐	Cuban, Mexica	n, Puerto	ecify Yes or No Rican, etc.)	Blad	e-America ck, White, e	itc.			
72 ho	15. Decedent's Edu (Specify only highest grad		16a. Dece	dent's Usual Oc	nt's Usual Occupation ad of work done during most of working NOT use retired)					ustry			
ind ZIZIS-UUZU be filed within 72 hours ef tal Hygiene. d other than "natural", or event, the Hidical Exam Be Completed by F	Elementery/Secondary (0-12)	College (1-4or 5+)		rier	tired)	St Of WORK		U.S.	. Post Offic				
al Hygin other vent, by	17. Father's Name (First, Middle, Last)				18. Moth	ner's Name	(First, Middle	, Maiden Sumen	10)				
re, Maryland Z. I. I and 2 should be filed will Health and Mental Hygiens from Z. Is marked other that other traumatic event, the To Be Com	Elam Monroe Sto	ouffer		71.11	Ali	ce M	ay He	intzelm	nan				
2 sho send h	19e. Informent's Neme/Retationship (T)	rpe, Print)	19b. Meili	ng Address (St	reet and Numl	ber or Run	il Route Numb	er, City or Town,	State, Zip	Code)			
e, March o Health o em 27 la	Lillian I. Stor	iffer Wife	517	Frederi	ck Str	eet	Hagers	town, Ma	rylar	nd 21740			
allimore, wait. Pages 1 and partment of Health portant: if hem 27 y Injury or other tree.	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donetion 5 ☐ Other (Specify)	Removal from State	b. Plece of Dispo cemetery, cre ROSE Hil	osition (Name of metory or other 1 Cemet	plece) ery	2/	Date 10/99	20c. Location -	_	m, State Maryland			
Daltimo pemit. Pages Department of Important: If I any Injury or pings.	Signature of Funeral Service Licental Serv	much	G	erald Nuneral	. Minn Home	ich	Hager	. Potoma		ceet and 21740			
Physician /Medical Examiner st the burial-transit edical Examiner	Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Due to	cute / o (or es e conser ulatura o (or as e conser	quence of):	eccur	for new	lure	<i>a.</i>	1	Delege			
1 0 in 8	Cause (Disease or Injury that initiated events resulting in death) Last		o (or es a consecuent	Juence of):	heur	l X	aclu	L		lon			
. 0 0 0	Pert II. Other significant conditions con	ntributing to death but not	resulting In the u	nderlying cause	given in Pert	f.	23b. Did	tobacco use co	ntribute to	the cause of death			
es that the death or good by the attend be detached for us by Physician	duodenal ulceral	in with G	FI bleed	Dey		51	10	Yes 2 No	3 Prob	ebly 4□Unknow			
s been s 2 should				0				an autopsy ormed?	con	re autopsy findings illable prior to apletion of cause leath?			
yelden: The last secutificate he director, page							10	Yes 2 No	10	Yes 2□ No			
delen: The certificate rector, pag	25. Wes case referred to medical				26. Plac	e of Death	(Check only	one)					
Physical this ce all direction To E	examiner?	lospitel: 1 Inpatient 2	ER/Outpatie	nt 3 DOA	Other: 4 N	lursing Ho	me 5 Res	idence 6 Oth	er (Specify)			
J = = 0	27. Manner of Death 1 Natural 5 Pending investigation	28a. Dete of Injury (Month, Day Year	28b. Time o Injury		njury et Work? 1 🗌 Yes 2 🗆		28d. Describe	how injury occur	red				
s after of all Direct of in by Certific	3 Suicide 4 Homicide Could not be determined 28e. Place of tnjury - At home, ferm, street, factory, office building, etc. (Specify)							(Street and Numb wn, State)	per or Rura	Route Number,			
Hospi 24 hou Funer tely fill	29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	nician: To the best of my liner; On the basis of exam and manner stated.	knowledge, deat inetion end/or in	n occurred at the vestigation, in n	e time, date a ny opinion, de	nd place, a ath occum	and due to the ed at the time,	cause(s) and made date end place,	anner as st end due to	ated. the ceuse(s)			
within 2 within 2 To the comple	29b. Signeture end title of certifier	~ 0		29c. Lic	ense number			29d. Date signe	d (Month, I	Day, Year)			
	Huruld 11 1/2	un Whie		7	12194	1		Feb s	3 199	9			
	30. Neme end address of person who co		Item 23a) (Type,	Print)	enstea		head	200	60	D			
State	31. Dete filed (Month, Day, Year) FEB 0 9 19	32. Registrar's Si	gnature	1	115/800		un						



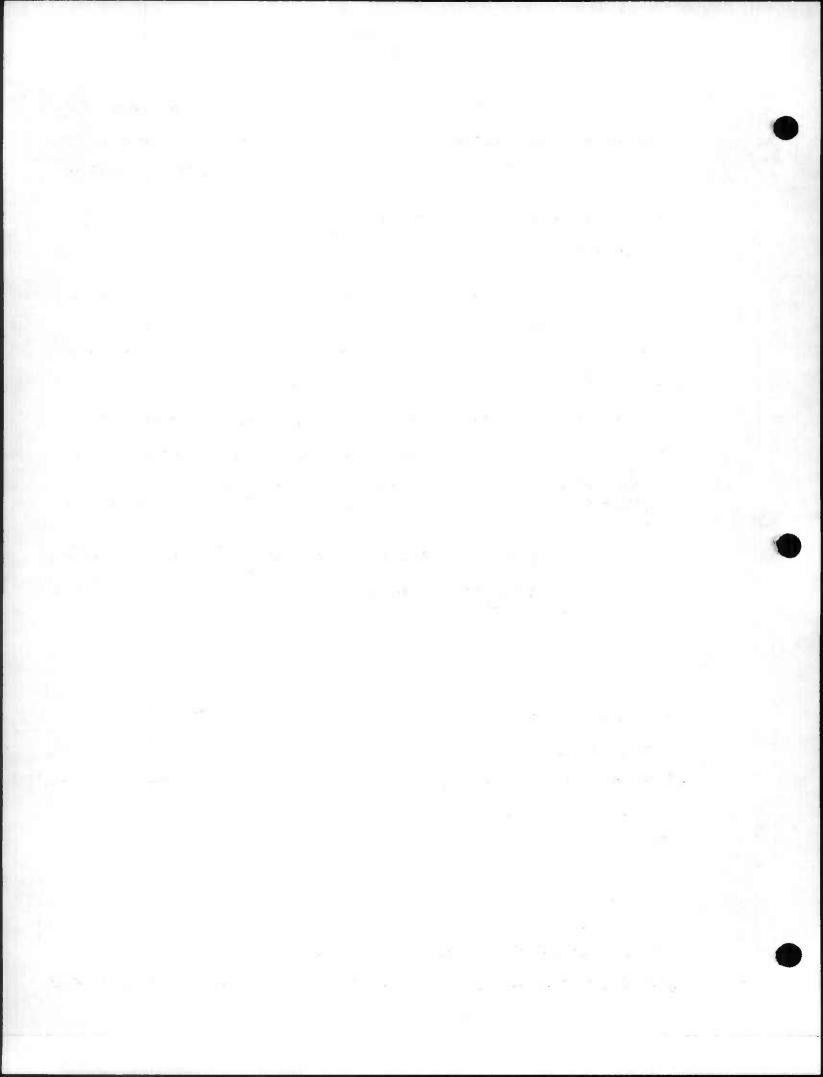
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath **Physician** Month Mae Smith Doris 6030 F84 /Medical 4a. Fecility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester General Hospital Cambridge Dorchester 5. Social Security Numbar If Undar 1 Year If Undar 24 Hrs.
Months Deys Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (Stata or Foreign **Funeral** 1 □ M 2XXF Deys Mary Land 68 220-26-1622 Yrs. Director Usuel Residance of Decedant 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits filed within 72 hours after death with the Maryla Maryland Dorchester Cambridge Yes 2 No Director must be notified 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 109 Talbot Avenue 21613 US Негля 23а Completed by Funeral 12. Wes Decedant Evar in U,S. Armed Forces? Wes Decedanl of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Ricen, atc.) 14. Race - American Indien, than "natural", or iten the Medical Examiner Bleck. Whita, atc. 1 Nevar Married XX Married 1 ☐ Yes ZXXNo If Yas, Giva Year or Dates: Baltimore, Maryland 21215-0020 White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Dacedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decadent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Hygiens. Elementery/Secondary (0-12) College (1-4or 5+) Seamstress Garment Factory 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nema (First, Middle, Meiden Surneme) Pages 1 and 2 should be nent of Hesith and Mental Jessie Bramble Lydia Tall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rurel Routa Number, City or Town, State, Zip Coda) nt of Health a If them 27 is or other train Arthur M. Smith 109 Talbot Avenue Cambridge, Maryland 21613 Husband 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata XX Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) MD Veterans Cemetery 2/10/99 Hurlock, Maryland 21. Signature of maral Sarvice Licansea 22. Nama and Addrass of Facility Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613 23a. Part1 Finter the disaasa, or complications that causad tha daath. Do not entar tha mode of dying, such es cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on each lina. Physician Chronic Obstructive LUNG Disense /Medical Immediata Causa (Final disaasa or condition resulting in daath) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit Sequentially list conditions, if any, leading to immadiata causa. Enter Undarlying Ceusa (Disaasa or Injury that initiatad avants resulting In daath) Last P.O. Box 68760, Completed by Physician/Medical Dua to (or es e consequance of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Division of Vital Records. 24e. Wes an autopsy performed? 24b. Wara autopsy findings available prior to complation of cause of daeth? coporosis Condine Arrhythymin 1 Yas 28 No. 1 ☐ Yes 2 No 25. Was casa referred to medical axaminar? Be 26. Placa of Daath (Check only one) Hospital: 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Spacify) 1 Yas 2 No Certification: To 28e. Deta of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending invastigation 1. Natural 1 Yas 2 No 2 Accident 3 Suicide 6 Could not be datarmined 28a. Placa of Injury - At homa, farm, streat, fectory, office building, atc. (Spacify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a, Cartifian Medical 🚈 🗲 Cartifying Physician: To tha bast of my knowledga, daath occurrad at the tima, data and place, end dua to tha causa(s) and mannar as statad. 2 Madical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred et tha time, data and place, end dua to the causa(s) and mannar stated. 29b. Signature and titla of cartifiar 29c. Licansa number 29d. Date signed (Month, Day, Year) 30. Name and eddrass of person who complated cause of death (Itam 23a) (Type, Print) Hurbel MD 21643 Faclden 300 mo 31. Data filed (Month, Dey, Yaer) 32. Ragistrar's Signature State FEB Registrar

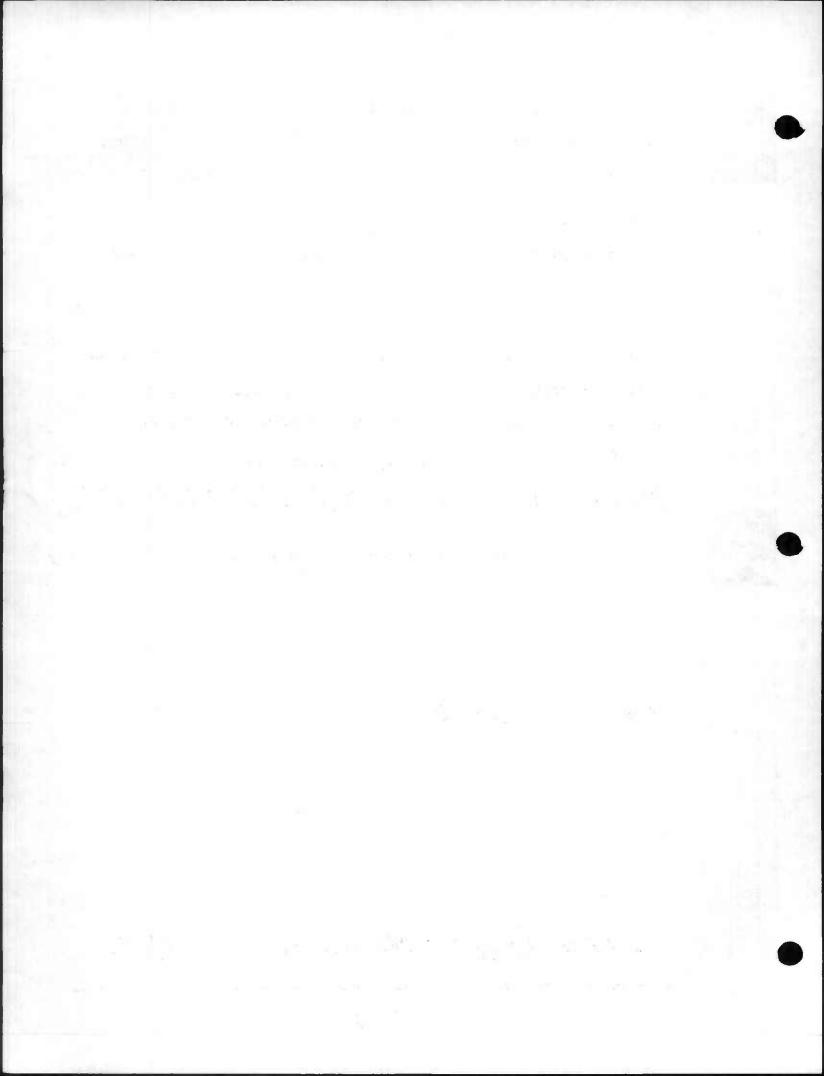
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		1. Dacedant's Nama (First, Middla, L	ast)		rtificate of		2. Data of Daat	og. N o. h	3	. Tima of Death
Physic		Martha Nat	alie Po	rter Ste	eele		Month Feb. 8	, 1999	Yaar 6	:45 pm
/Med Exami		4e. Fecility Nama (If not institution, gi		reer Dee		4b. City, Town, or Lo		4c. County		•45 bill
Exam	1161	William Hil	1 Manor			Easto	n		lbot	
Funeral		5. Social Sacurity Number 6.	Sax 7. Ag	a (In yrs. last birthdey)	If Undar 1 Year	If Under 24 Hrs.	8. Data of Birth (Month, Day,			(State or Foreign
Director		126-16-3921 Usual Rasidance of Decedent	1□ M 2∰F	87 Yrs.	Months Days	Hours Min.	July 2	0, 191	1 New	York
Stat	5	10a. Stata 10b. County	albot	10c. City, Town or Lo						Insida City Limits
28a-1	ect	Maryland Ta	IDOL		Easton)- Oh(14		
23a or	Funeral Director	10 Shannon Te	errace		10f. Zip Coda 216	501		og. Citizan of W	S.A.	
al', or items 23a or 28a-f show Examiner must be notified at	by	11. Marital Status 1 Nevar Married 3 Widowed 4 Divorced	12. Wes Dacedant Armed Forces? 1 ☐ Yas 24 If If Yas, Giva Yeer or Datas:	No	Was Dacedant of H If Yes, specify Cubs 1 ☐ Yas 2 🎇 No	tispanic Origin? (Spean, Maxicen, Puarto Specify:	ecify Yas or No- Rican, atc.)		- Amarican I k, Whita, etc. Whi	
nygiene. ther than "natural", ent, the Medical Exa	Completed	15. Decedant's E (Spacify only highast g Elemantary/Secondary (0-12)	Education rada complated) Collage (1-4or 5)+)		pation during most of work d)	ing	6b. Kind of Bu	sinass/indust	
å f		17. Fathar's Nama (First, Middla, Las		Tea	cher	18. Mother's Name	a (First, Middla, N		ation	
\$ 0 S	To Be	Harold E. Port					tte Tho		.,	
ZEE	-	19a. Informant's Name/Ralationship	and Number or Run			Stata, Zip Coo	da)			
		Austin N. Stee				Terrace				
T 1		20a. Mathod of Disposition 1 Burial 2 Cramation 3 4 Donation 5 Other (Speci	☐Ramoval from Stata	20b. Placa of Dispo cematary, cres	sition (Nama of matory or other place	ca)	Date 2	20c. Location -	City or Town,	Stata
Important: I any injury o		21. Signature of Funeral Service Lice		22	. Name end Addra	natory 2 ss of Facility Bromwell			ridge	
_ 4 4		talled torre	ex ben	well.	308 High	st., C	ambride	ie, MD	2161	3
		3a. Rart1. Entar tha didental, or conshock, or heart failure. List only	nplications that ceusad y ona causa on each iir	the daath. Do not ant	ar the moda of dyin	ng, such as cerdiac	or raspiratory erra	st,	Ap Inte	proximeta arval Batween
sician edical		Immediata Causa (Final disaasa or condition	No	- Hode	kins	Lymph	OMA		On	set end Death
aminer	Jer	rasulting in daath)	a	Dua to (or as a coosed	quance of):					, , , , ,
physician end s the buriel-transit	Examiner	Saquantially list conditions, if any, laading to immadiata ceuse. Enter Undarlying Causa (Diseesa or Injury	b	Dua to (or es e consac	juance of):					
	Medical	that initieted avants resulting in death) Last	d	Due to (or as a conseq	uance of):					
e ettending ad for use e	Physician/N	Part II. Other significant conditions	contributing to death by	ut not resulting in the u	ndarlylng cause giv	ren in Part I	23b. Did tol	hacco use con	tribute to the	cause of death?
ed by the deteched		Alheimers		contis	ildariying doddo giv	of all the				y 4 Unknown
s been sign 2 should be	Completed by						24e. Wes ar perform		evailab	autopsy findings ola prior to ation of ceusa th?
ete he	HO:						1□ Ye	s 20 No	1 🗆 Ya	s 2 No
certificete rector, pag	Bec	25. Was casa rafarrad to madical				26. Placa of Daati				
0 0	To B	examinar?	Hospitai: 1 ☐ Inpatie	nt 2□ ER/Outpatier	t 3 DOA Oth		ma 5 ☐ Rasida		or (Specify)	
5 0		27. Mannar of Death 1. Naturel 5 Panding 2 Accidant invastigation	28e. Data of Injui (Month, Day	y 28b. Tima of	28c. Injur Wor		28d. Dascribe ho			
To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicida 6 ☐ Could not t 4 ☐ Homicida datermined		ury - At homa, farm, str (Specify)	aat, factory, office		28f. Location (Str City or Town		er or Rural Ro	outa Number,
To the Funeral Di completely filled in	edicai (29a. Certifiar (Check only one) Certifying Plants 2 Medical Example 1	hysician: To the best of miner: On the besis of and manner sta	examination and/or inv	occurred at the tin vastigation, in my o	na, data and place, pinlon, daath occurr	and dua to tha ca ed at tha tima, da	usa(s) and mer te and plece, e	nner es steted and due to tha	d. ceuse(s)
Toth	M	29b. Signature end titla of continue	. Buzer	~	29c. Licans	a number	29	d. Data sighed	(Month, Day)	, Year)
		30. Nama and eddress of parson who			· ·	J. J			. /	
Sta	to	gichard A. Bu 31. Data filed (Month, Day, Yaar)	argoyne,	r's Signatura			e, East	on, M	D 216	01
Regist				eva G.	Spark	41				

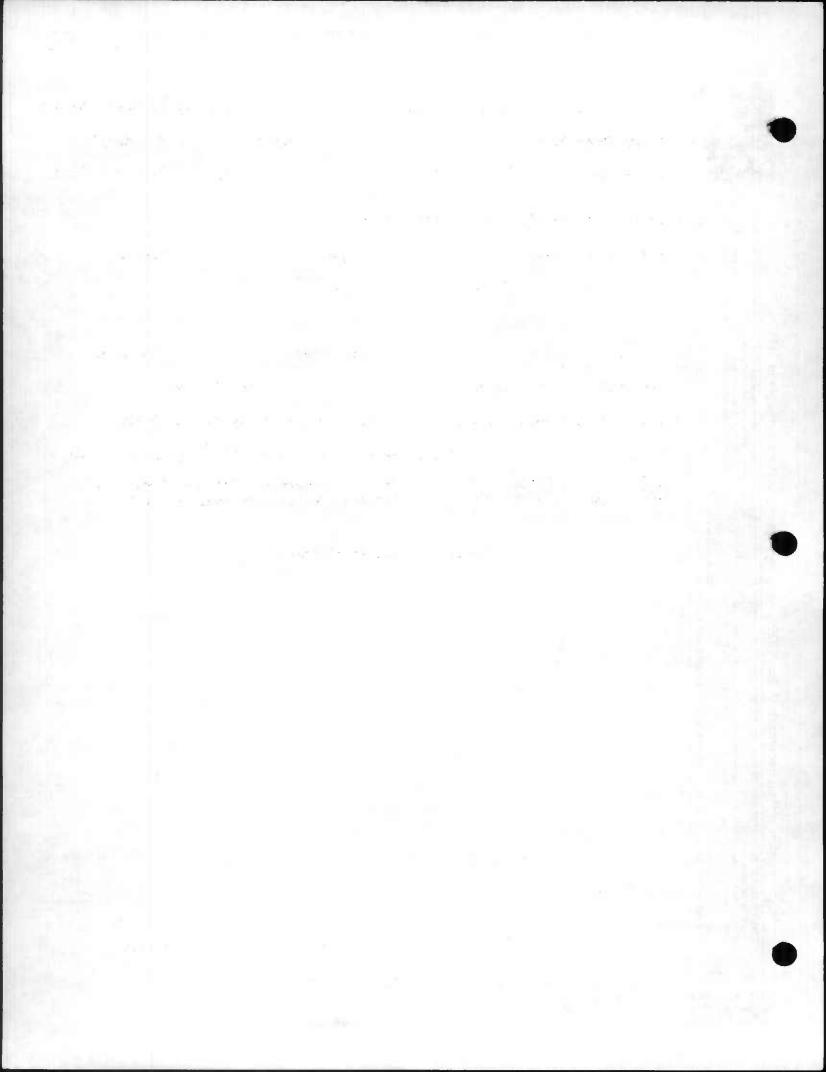
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			Ce	rtificate of	f Death	Re	g. No.					
	1. Decedent's Name (First, Middle, I	ast)				2. Date of Deat	h	Mar.	3. Tima of	Death		
Physician	Helen	a Adams T	hompson			Month Februar	Day	Year 999	6:30	PM		
/Medical Examiner	4a Facility Name (If not institution, g		·		4b. City, Town, or		4c. County		0.50	2.44		
Examiner	17559 River Dr				Piney P	oint	C+	Mary	l _{er}			
			rs. last birthday)	If Under 1 Yaa				- 4		or Foreign		
Funeral Director	577-07-4249 Usuai Residence of Decedent	1□ M 2\\(\overline{\Omega}\). F	82 Yrs.	Months Day		8. Date of Birth (Month, Day, May 14			lace (State o try) cyland			
we a	10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits				
the Marylar 28a-f show northed	Maryland St. Ma	revet o	Piney	Point					1 🗆 Yes	2X No		
the h	10e. Street and Number	13 3	Tilley	10f. Zip Code		14	0g. Citizen of V	What Coun	to/2			
DI Di									uy.			
eth w	17559 River Dr			206			U.S.					
d 21215-0020 filed within 72 hours after deeth with the Maryland bygiena. ther than "naturel", or items 23a or 28s-f show ont, the Medical Earn from the mortified. e Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedant Evar in Armed Forcas? 1 Yas 2 No It Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ N	f Hispanlc Origin? (S aban, Maxican, Puart o Specify:	pecity Yas or No- o Rican, etc.)	Blac	a - Amarica ck, White, o	etc.			
"nature	15. Decedent's	Education	16a. Dece	dent's Usual Occ	upation	4.1.	16b. Kind ot B	usiness/Ind	dustry			
1 21215-0 ed within 72 hor ygiene. her than "nature ft, the Medical Completed	(Specify only highest g		e complated) (Give kind of work life. DO NOT use			king						
Maryland 2121 32 should be filed within h and Montel Hygiene. Its marked other than "I to mere treumatic event, the Mere To Be Comple	Elementary/Secondary (0-12)	College (1-40r 5+)		Homem	akar		Own	Home				
The state of the s	17. Father's Name (First, Middle, Lat	st)		nomen		ne (First, Middle, A			2			
Maryland nd 2 should be file lith and Mentel Hy 27 is marked other treumatic event					A = :	to Curti	20.00					
arylan should be and Mentel marked o umetic eve	Benjamin Gor					ta Guyth		0	0.41			
Aan and is m	19a. informant's Name/Relationship				at and Number or Ru				Code)			
2 = 2 .	Bernard Floyd Th	ney Point										
D -15	20a. Method of Disposition 1XI Burial 2 Cremation 3 Ramoval from Stata 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, cremetory or other place) St. Francis Xavier Cemetery 20c. Location - City or Town, State 2/8/99 St. George's Island											
Baltimo pemit. Pages Department of Important: If it any injury or e	21. Signature of Funeral Service Lic	Ansee Garline	M		y-Gardine							
	23a Part1 Enter the disease or co	molications that caused the d	leath Do not en	. O . Box 2	70, Leona	rdtown, I	4D 2065	0	Approximat	te		
	23a. Part1. Enter the disease, or co shock, or heart tailure. List on	y one cause on each line.			y mg, out mad out and	or respiratory and		1	Interval Bet Onsat and	tween		
Physician	Immediate Course (Final											
/Medical Examiner	disease or condition described metastatic cancer of Ovaries (sease) a. Metastatic cancer of Ovaries								2 mth	S		
Contract of the Contract of th	Testiting in death)	Due t	o (or es e conse	quence of):				1				
P = 0								T.				
Geth certificete be executed e ettending physician and ad for use es the burial-transit sician/Medical Examiner	Sequentially list conditions,	Due t	o (or as a conse	quence of):								
68760, ificete be exe physician a se the burial-ledical Ex	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury							1				
Vsici	that initiated events	c. Dua to	o (or as a consec	quence of):								
	rasulting in death) Last											
nding use		d										
Box eeth cert ettendin for use												
that the deeth certing of by the ettending detached for use of Physician/M	Part II. Other significant conditions	contributing to death but not	resulting in tha u	underlying causa	given in Part I.	pacco use contributa to the cause of dea						
P de by	C) Estimated at 1					1 ☐ Yes 2 ☐ No 3			bably 4 🔯	Unknov		
S & E & O												
The lew require tale has been signated a should Completed						24a. Was a perform	n autopsy ned?	24b. We	ere autopsy l ailable prior l	tindings to		
S S S S S S S S S S S S S S S S S S S								COI	mpletion of death?	ceuse		
The lew rate has paga 2.						1□ ٧	s 2 X No	10	Yes 2	l No		
ital	25. Wes cese referred to medical								J 100 EL			
Of Vital I Physician: The This certificate rel director, pag I: To Be Co	exeminer? 1 Yes 2 No	Hospital:			Wher:	ath (Check only on						
T T T	1 Yes 2 2.No	1 L Inpatient		nt 3LI DOA	4 U Nursing F	fome 5 X Reside		-	y)			
Division of Vital or Attanding Physician: T after death. Director: After this certificat d in by the funerel director, pertification: To Be C.	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Dey Year	r) 28b. Time of Injury		jury at /ork?	28d. Describe ho	w injury occur	100				
Attending ar death. Ctor: After by the fune lifecation	2 Accident investiget			M 1	☐ Yes 2☐ No							
DIVIS lor Att after de Directe d in by t	3 Suicide 6 Could not determine	28e. Place of Injury - A building, etc. (Sp.	At home, farm, st	reet, factory, offic	ee .	28f. Location (St City or Town		ber or Rura	I Route Nun	nber,		
DIVISION (bit or Attending P rs after death. al Director: After t led in by the funer Certification:												
DIV To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b Medical Certi	29a. Certifier 1 X Cartifying F (Check only one) 2 Medicat Ex-	Phyalcian: To the best of my aminar: On the basis of exam and manner stated.	knowledge, deet ination and/or in	th occurred at that evestigation, in my	tima, data and place y opinion, death occu	e, and due to the coursed at the time, d	ause(s) and mate end place,	anner as si and due to	tated. the cause(s	s)		
ithin on the omp	29b. Signatura and titla of certifiar	1110		29c. Lica	nsa number	2	9d. Date signe	d (Month,	Day, Year)			
F ≥ F ŏ		2-1/15										
	/1	11/5		D3	3470		2/8/9	9				
	1/	Ald I among the second										
10	30. Name and address of person wh	completed cause of deeth (Item 23e) (Type									
6	30. Name and address of person wh	//		, Print)	MD 20636							
(c) State		//	Ho1	, Print)								

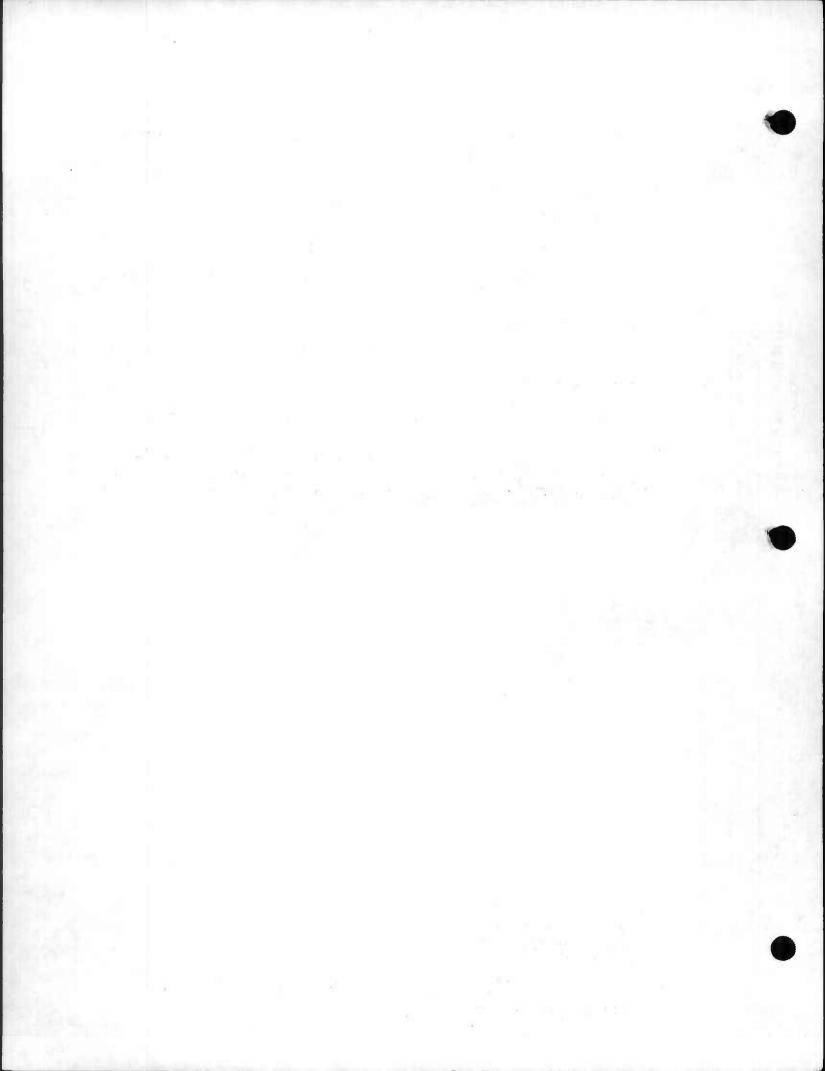
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State of Maryland / Department of Health and Mental Hygiene 9 0 5 0 5 3

			Ce	rtificate of	Death		Reg. No.			
	1. Decedent's Name (First, Middle, Last)				2. Dete of De Month	eath Day	Year 5 . Time of Deal		
Physician /Medical	Marjorie Gorham TI	HOMAS				Februa	1 11	999 2011		
Examiner	4e Facility Name (If not institution, give	street and number)			4b. City, Town	, or Location of Deat	h /4c. County	of Death		
	Washington County	Hospital			Hager	stown	Was	hington		
eral ctor	5. Social Security Number 6. Se 123-32-7821	7. Age (In your 86	rs. last birthday) Yrs.	Months Days		Min. 8. Date of Bir (Month, De Dec. 3	th ly, Year)),1912	9. Birthplece (State or For Country) New York		
	Usual Residence of Decedent 10a. Stete 10b. County	10c.	City, Town or Lo	ocation			10d. tnslde City Limits			
Director	Maryland Washingt	ton	H	agerstow	n			1 ☐ Yes 250		
	17829 Woodcrest 1	Road		10f. Zip Code	21740		10g. Citizen of Whet Country? USA			
by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2≦ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cul 1☐ Yes Ø☐ No		i? (Specify Yes or No Puerto Rican, etc.)	14. Rac Blac Specify	e - American Indian, ck, White, etc. c: White		
Completed	15. Decedent's Edu (Specify only highest grad		16a. Dece (Give	dent's Usuel Occu kind of work done DO NOT use retir	upation o during most o	l working	16b. Kind of Bu	usiness/Industry		
dmo:	Elementery/Secondary (0-12)	College (1-4or 5+) 5		her and			publi	c school		
Be	17. Father's Name (First, Middle, Last)				18. Mother's	Neme (First, Middle	, Maiden Sumem	10)		
To	Albert Gorham The	omas			Grac	e Thorne				
	19e. Informent's Neme/Relationship (T) J. Paul Reno	rpe, Print)				., Hagers				
lank or	20e. Method of Disposition 1 🔯 Burial 2 □ Cremation 3 □ F 4 □ Donetion 5 □ Other (Specify)	lemovel from State	20b. Place of Disposition (Neme of commetery, cremetory of other place) Woodlawn Cemetery 2/11/99 Canandaigua, N.							
	21. Signature of Funeral Service Licens	m.	2	Name end Add		MINNICH				
	23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the de	eath. Do not en					Approximate		
n nl r	Immediate Ceuse (Final disease or condition resulting in death)	Conglest Due to	(or es e conse	Yeart quence on:	Failure		et I	1 week		
al Examiner	Sequentially tist conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events	Due to	(or es a consec	quence of):						
Medical	that initiated events resulting in death) Last		(or as a consec	quence of):						
clan						-				
Physician/M	Part II. Other significant conditions con	ntributing to death but not r	esulting in the u	inderlying cause g	iven in Pert I.		tobacco uae co Yes 2□ No	ntribute to the cause of dea 3 Probably 4 ☑ Unkr		
Completed by							en eutopsy ormed?	24b. Were eutopsy findin evailable prior to completion of cause of death?		
5						10	Yes 25 No	1 ☐ Yes 2 ☐ No		
BeC	25. Was case referred to medical				26. Place of	f Deeth (Check only				
To B	examiner? 1 Yes 2 No	lospital:	☐ ER/Outpatie	nt 3 DOA	ther	ing Home 5□ Res		er (Specify)		
	27. Manner of Death 1 Netural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o	28c. tni	ury at ork? ☐ Yes 2 ☐ No	28d. Describe	how Injury occur			
edical Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - Al building, etc. (Spe		reet, factory, office		28f. Location (City or To	Street end Numb wn, Stete)	er or Rural Route Number,		
dical (29a. Certifier (Check enly one) 1 Certifying Physical Examination (Check enly one)	nician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, deat nation and/or in	h occurred et the t vestigation, in my	time, date end p opinion, deeth	place, end due to the occurred et the time,	cause(s) end ma date end plece,	anner es stated. and due to the ceuse(s)		
Ž	29b. Signature and title of certifier	TIL		29c. Licer	nse number		29d. Date signe	d (Month, Dey, Year)		
	I lever of	telw 10		74	440	3	2/91	199		
	30. Name and ddress of person who co	impleted cause of death (It	tem 23a) (Type,	Print)	/.	St. Ha		1		
State	31. Dete filed (Month, Day, Year)	0/1 M.D. 32 32. Redistrar's Sig	nature a	4ntie1	am	17. Ha	9. Md			
State gistrar	FEB 0 9 199	19	6.	Soas	41		,			



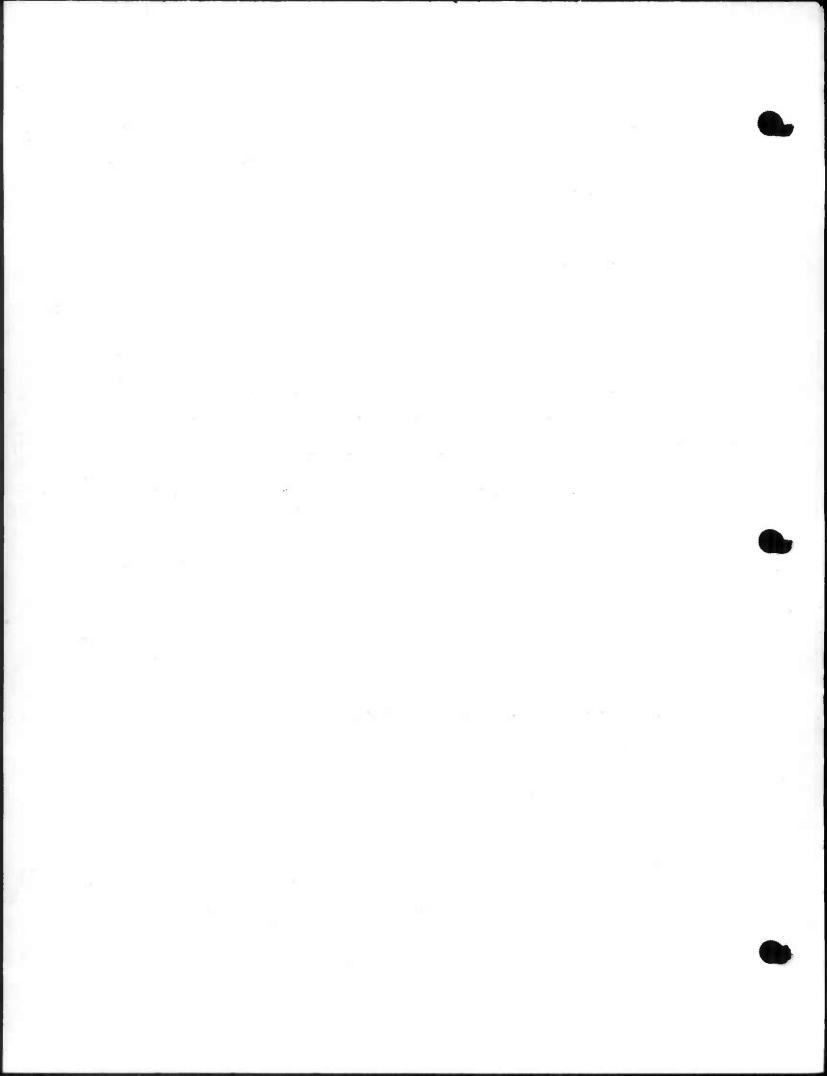
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation, or remoral.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physical	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene pr	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other t	

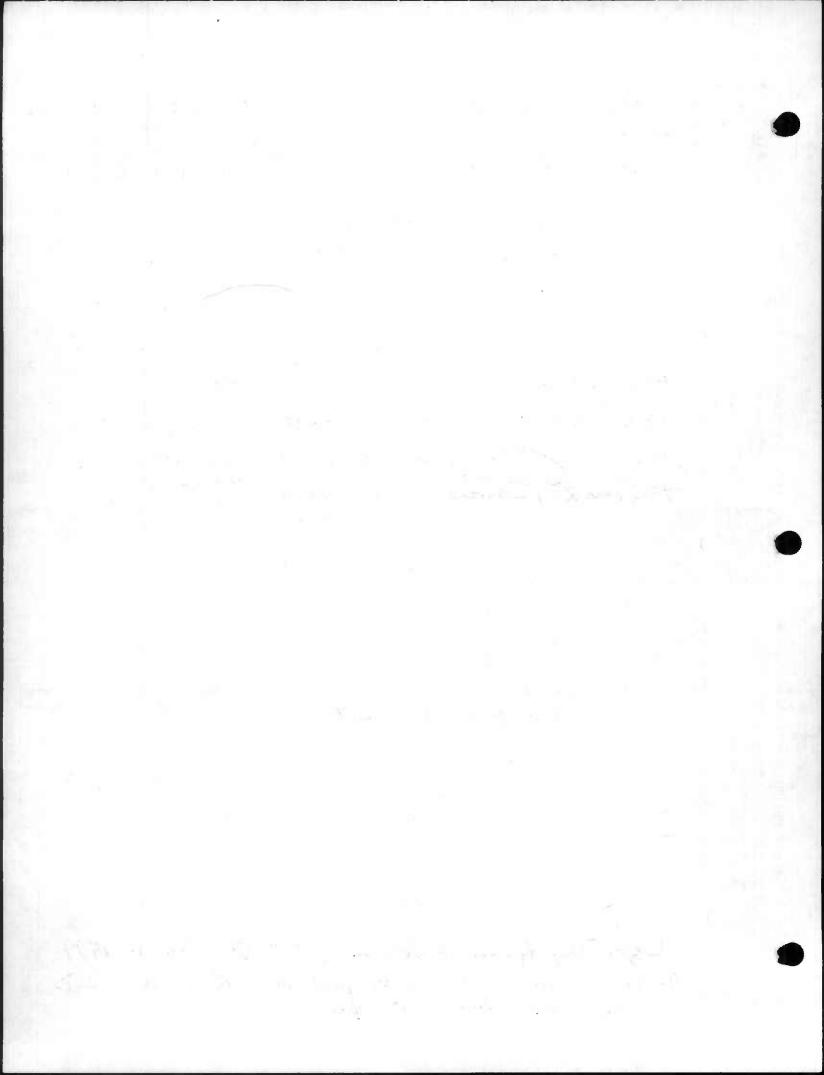
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	1 - FOR STATE REGISTRAR	STATE OF MARY	LAND /	DEPAR	TMENT	OF H	EALTH AND	MEN	TAL HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, Last)							2. D.	ATE OF DEATN			3. TIME OF DE	ATN
	Esta Mae TROUPE							F	ebruary	"5 , 1	999	11:30	a.mw
	4. SOCIAL SECURITY NUMBER		E (In yrs. las	t birthday)	IF UNDER		IF UNDER 24 HRS.	7. D/	TE OF BIRTN lonth, Day, Year)			PLACE (State or	
	212-74-1830 9a. FACILITY NAME (If not institution, give si	1 M 2 K F	91	YRS.	MONTHS OF CITY	DAYS	HOURS MIN.	Au	gust 5,	1907	Ma	ryland	
œ	11 West Baltimore				Hagr			EAIN		% COUNTY OF DEATH Washington			
DIRECTOR	RESIDENCE OF DECEDENT	Bereet			nagi	SLOV	711			Wa	.511111	gton	
	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN O	R LOCAT	ION					10d. INSIDE CI LIMITS?	TY
	Maryland Washin			Hag	erstown					1 K YES 2] NO		
וַאַ	10a. STREET AND NUMBER		101	ZIP CODE					NAT COUNTRY	>			
FUNERAL	11 West Baltimore							740			SA		
2	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER FORCES? 1 YES	IN U.S. AR	MED			ENDENT OF NISPAP polity Cuban, Maxica			or No-	14. RACE Black	— American In White, alc.	dian,
B	3 🔀 Widowed 4 🗌 Divorced	IF YES, GIVE WAR OR	DATES		1	YES	2 NO Specif	y:	,		Speck	whi	to
	15. DECEDENT'S EDUC	CATION	18a. DE	CEDENT'S	USUAL OC	CUPATIO	IN .		16b. KIND OF BUS	INESS/IND	USTRY	WILL	
ETED	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	/G	ive kind of a Do NOT us	vork done o	luring mo	st of working						
COMPL	9	0			hom	emak	er		he	er ow	n ho	me	
Ö	17. FATNER'S NAME (First, Middle, Last)						18. MOTHER'S NA	ME (Fi	st, Middle, Maiden	Sumame)			
BE	Elmer Lee Gordon							Laura E	,				
0	19a. INFORMANT'S NAME (Type/Print)	.1.					nd Number or Rural						
	Jean Barnes - dau				_	_	Drive,	на					
	20a. METNOD OF DISPOSITION 1 K Burial 2 Cremation 3 Rame		netery, cre Rest					1		CATION —			
	4 Donation 5 Other (Specify)		Kest	Have					/99 Ha				and
	Sign	m/.	100	./			D ADDRESS OF FA						1 = / 0
	20091	" am	nee	n			E.Wilson					Md. 2	1/40
	23. PART i. Enter the disesses, or o shock, or heart failure.	omplications that caus List only one cause on	ed the de each line	sth. Do r	ot enter	the mo	de of dying, auc	h aa c	srdisc or respi	ratory arr	eat,	Approxi	mate Between
	iMMEDIATE CAUSE (Finsi disease or condition	DDODADLE	DUDT										nd Death
1		PROBABLE DUE TO (OR AS				MIN	AL ANEUR	YSM				6 mo	nths
,					,.								
HIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS	A CONSE	DUENCE OF	-):								
2	Cause, Enter UNDERLYING CAUSE (Disease or injury	>				_							
=	that initiated eventa resulting in death) LAST	DUE TO (OR AS	A CONSE	DUENCE OF	T):								
SE E	Total III and	J											
AL (PART II. Other significant condition	s contributing to death	but not r	esulting	n the un	derlying	cause given in	Part i			24b.	WERE AUTOPSY	
EDIC									PERFOR			AMAILABLE PRIO	
ME												OF DEATH?	NO
ž	DID TOBACCO USE	CONTRIBUTE TO	CAU	SE OF	DEAT	TH Y	ES NC		1		İ		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:					ACE OF DEATH (Ch	eck onl	y one)				
2	1 TYES 2 X NO	1 Inpatient 2 ER/Ou	itpatient 3	□ DOA	4 Num		5 K Raeldence	8 🗆 0	ther (Specify)				
	27. MANNER OF DEATH 1 Natural 5 Pending	(Month, Day, Year)		28b. TIM INJ	E OF URY	28c. INJ WO	JRY AT RK?	28d.	DESCRIBE NOW II	NJURY OCC	CURED		
'n	2 Accident Investigation				М		ES 2 NO						
3	3 Suicide 8 Could not be datarmined	28s. PLACE OF INJUR building, atc. (Sp	ecify)	me, farm, a	itreet, facto	ery, offici	'	281. [OCATION (Street a City or Town, State)	nd Number	or Rural R	oute Number,	
COMPLETED	29a. CERTIFIER		oc will the						SANIE IN SO				
E		CIAN: To the best of my kno R: On the basis of examinat											CONTRACT
	296. SIGNATURE AND TITLE OF CENTURES		ion and/or	- Invaligatio	11, 111 my O	prinori, d			ista and piaca, and				
2	10/6 1M	_					DO6041					(Month, Day, Yea	r)
2	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF I	EATN /ITF	W 271 (Time	Print		700041	_		- 0	2081	.999	
	E. R. Lardizabel,					Ave.	, Hagers	stor	vn, Md.	2174	0		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIG	NATURE	F									
	FEB 1 6 1999 January B. Sparky												



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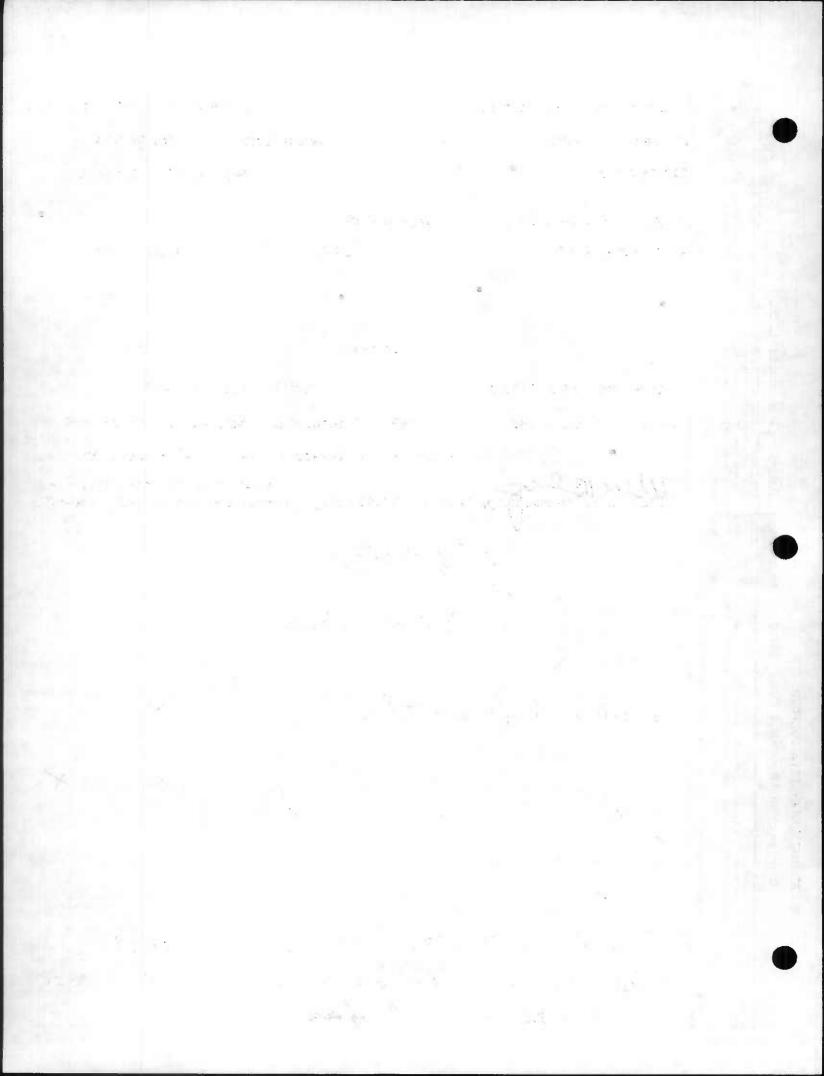
Department of Health and Mantal Hygiana. Important: If Itan 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	4e. Fecility Name (If not institut 22621 Jeffer). 5. Social Security Number 214-16-1542 Usuel Residence of Decedent 10a. State 10b. Coun Md. Wash 10e. Street and Number 22621 Jeffer 11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 1 Never M	Ellsworth U ion, give street and num. Son Blvd. 6. Sex 1 M 2 F ity rington 12. Wes Deced Armed Forc 1 M Yes, Give Year or Dat 12. Wes Deced Armed Forc 1 M Yes, Give Year or Dat 13. Yes 2 11 Yes, Give Year or Dat 14. Yes, Give Year or Dat 15. Last) 16. Last) 17. Last) 18. Last) 19. Last)	### Age (In yrs. las 85 10c. City, 10c. City, 10c. City 10	Yrs. Town or Lo Smit! 18e. Deced (Give life. I 19b. Mailir 2262 ce of Disponetery, crem	Months D ocation hsbwg 104. Zip Co 21 Was Decedent If Yes, specify 1 Yes 2 2 dent's Usuel O kind of work a DO NOT use n Electric ng Address (Si	ride 1783 10 of Hispanic Origin? (S Cuban, Mexican, Puerl (No Specify: Indicated the desired) 18. Mother's Nar	2. Date of Death Month Februar. Location of Death DWG 8. Date of Birth (Month, Day, JUNE 18	Day y 9, 199 4c. County of Washi Year) 1913 Dg. Citizen of Who U.S. 14. Raca- Black, Specify: 16b. Kind of Bush Aircraf. Meiden Sumame) Hoover	Death .ngton .Birthpiece (State or For Country) Maryland 10d. Inside City Lington 1 Tyes XX at Country? A. American Indian, White, etc. White ness/Industry t Plant	
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	00 0 14 0 1 11 11	x. pa	vio	Do	avis Fu	neral Home	12525 Br Smithsbu	radbwry i vra.Md.	Ave. 21783	
as the	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b	Due to (or a	s a conseq	quence of):	omag				
		d								
ed by the ettend datached for us	Ce Ceral	CATULE	eath but not resulting in the underlying cause given in Part I. Acec Lat					23b. Did tobecco use contribute to the cause of deal		
see has been signed by the etter page 2 should be datached for I Completed by Physician							24e. Wes <i>a</i> n perform		24b. Were autopsy finding evelleble prior to completion of cause of death?	
Sete ha							1 ☐ Yes	2000	1 Yes 2 No	
rector, per	25. Was case referred to medical examiner?						th (Check only one)		
을 다	1 Aves 2 No 27. Menner of Death Natural 5 Pendi 2 Accident invest	Hospital: 1 Inp 28a. Date of 1 (Month, ligation	-	NOutpatient Bb. Time of Injury	28c.	Other: 4 Nursing H Injury at Work? 1 Yes 2 No	ome 50 Resider 28d. Describe how	nca 6 Other (Specify)	
Dir din din	3 ☐ Suicide 6 ☐ Could	not be 28e. Placa of	Injury - At home , etc. (Specify)	e, ferm, stre	n, street, factory, office 28f. Location (Street and City or Town, Stete)				or Rural Route Number,	
within 24 hours after To the Funeral Dir completely filled in Medical Cert	29a. Certifier (Check only one)	ng Physicien: To the be Examiner: On the basis and manner	s of examination	dge, deeth and/or inv	occurred at the	e time, date and plece, ny opinion, death occur	and due to the cau	use(s) end manne te end piace, end	er as stated. due to the cause(s)	
withir comp	29b. Signature and take of certific	er			29c. Llc	ense number	29	d. Date signed (M	fonth, Dey, Year)	
	166T	20014	0 .0	Ein	2	00	UX I	Tal in	1099	
	30. Name end address of person	wy completed cause of	of deeth (Item 23	Be) (Type, F	Print)	001	1	0 10	117/1	
	AnTHO L	1. Honal	WID 8	2/8	VIAR	INA AVE	= Hao	prof.	1 4.0	
State	31. Date filed (Month, Day, Year,	32. Reg	Israr's Signature	9 /	1	4	1175	-13 1000	u my	



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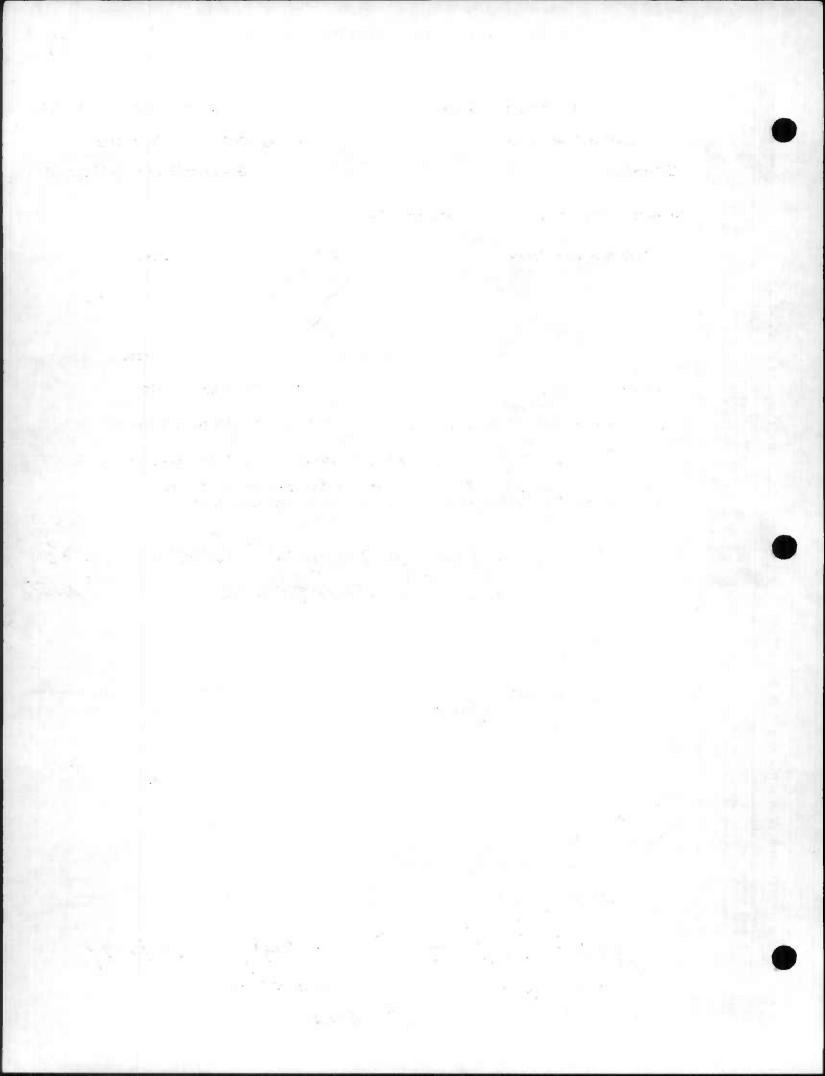
	Decedent's Neme (First, Middle, Lest)		Certifica	te of Dea		Reg	g. No.	3. Time of Death		
Physician	Eloise Henrietta Wol:	ford				Month	Day O 1	Yeer 999 2:41 p.m.		
/Medical	4a Facility Name (If not institution, give street en			4h City	Town, or Loca	EBRUARY	8 1 4c. County			
Examiner	St. Mary's Hospital	o namber)			ardtown		St. M			
	5. Social Security Number 6. Sex	7. Age (In yrs. la	ast hirthday) If Unde					-		
Funeral Director	312–16–7507			Days Hou	rs Min.	Dale of Birth (Month, Dey, 1	918	9. Birthplace (State or Foreig Country) Indiana		
hend #	10e. Slete 10b. County	10c. City	, Town or Location					10d. Inside City Limit		
Many Head	Maryland St. Mary's	Lex	ington Par	ck				1 ☐ Yes 2 ■ No		
h with the Mar 23e or 28e-f si III be notified	10e. Street and Number 45680 Roper Road		10f. Zi	101. Zip Code 20653				10g. Citizen of What Country? United States		
ING Z1Z13-UUZU be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23s or 28s-f show event, i'm Modical Examinar must be notified at Be Completed by Funeral Director	1 Never Married 2 Married 1 Ye	Decedent Ever in U,Sed Forces? Yes 2 ■ No s, Give or Dates:		edent of Hispenic ecify Cuban, Mex 2 No Spec		y Yes or No- can, etc.)		e - American Indien, ck, White, etc. White		
72 hc 72 hc 72 hc	15. Decadent's Education (Specify only highest grade comple	vied)	16a. Decedent's Usi (Give kind of w life. DO NOT	ual Occupation	nost of working	11	6b. Kind of Bu	usiness/Industry		
Z 1Z 1 D-UUZU ed within 72 hours aft ggiene. er than "natural", or it, III Modical Exam Completed by F		ge (1-4or 5+)	Homemal				n	/a		
The file of the double of the second of the	17. Father's Name (First, Middle, Last)			18. M	other's Name (First, Middle, M	aiden Sumen	ne)		
Via Went Ment Ment Ment Ment Ment Ment Ment M	George Washington Gibl	bons		Ed	ith Bla	nche Sa	wtell			
Maryland d 2 should be file th and Mental Hy 7 is marked othe traumatic event. To Be C	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Addres							
and and m 27 her tr	Samuel W. Wolford, Son	1			Rd., Ch	-		iana 46304		
DESILIMOTE, MATYIAND Z.IZ. permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, ITa Magnet.	20a. Method of Disposition 1 Buriel 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	from State Met	cametery, cremetory or other place) Metropolitan Crematory 2-9					city or Town, State		
Dentil. Departminity of the population of the po	21 Originate of Funeral Service Consequence (Consequence Consequence Consequen									
Physician /Medical Examiner	23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	espertoy	anest as a consequence of					fniervei Between Onset and Death		
eath certificate be executed etending physician and for use as the bunet-transit clan/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	as a consequence of as a consequence of	nlaru	2.					
death death death death	Part II. Other significent conditions contributing	to death but not resu	Iting in the underlying	cause given in P	art I.	23b. Dld tob	acco use co	ntribute to the cause of deat		
es that the death cert igned by the ettending be deteched for use e by Physician/M	Fractine (B)	Part II. Other algnificent conditions contributing to death but not resulting in the underlying of Functions Financial Definition of the second of the seco						3 Probably 4 ☐ Unkno		
requir should						24a. Was en perform	autopsy ed?	24b. Were autopsy findings eveileble prior to completion of cause of deeth?		
The law tie hes t page 2 s						1 ☐ Yes	3 2 No	1 ☐ Yes 2 No		
ysician: The light sector, page director, page	25. Was case referred to medical			26. P	lece of Death (Check only one)			
Physician: rthis certific and director,	examiner? 1 Yes 2 No Hospital:	1 Inpatient 2	ER/Outpatient 3 E	OA Other: 4	Nursing Home	5 Resider	nce 6 Oth	er (Specify)		
Affing Physics Affine this funeral di	27. Manner of Death 28a. I	Date of Injury (Month, Dey Yeer)	28b. Time of Injury	28c. Injury at Work?		d. Describe how				
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be		M me, farm, street, facto	1 Yes		f. Location (Str. City or Town,	on (Street end Number or Rural Route Number, Town State)			
ospital or hours aft ineral Di y filled in	29a. Certifier 1X Certifying Physicien: To	o the best of my know	vledge, deeth occurre	d et the time, date	e and place, an	d due to the ca	use(s) and ma	anner as steted.		
he Hospit in 24 hour he Funer pletely fill edical		manner stated.	on end/or investigatio	n, in my opinion,	death occurred	et the time, da	te and pieca,	and due to the cause(s)		
To the transfer of the transfe	29b. Signature and title of cartifier Walter Vul	enteen M		5016		29	d. Date signe	d (Month, Dey, Year)		
	30. Name and address of person who completed	cause of death (Item	23a) (Type, Print) 0 Box 5	27	Leona	roltow	n M	de 20650		
State		32. Registrar's Signal		land.						

DHMH 16 Rev 6/95



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	1. D	ecedent's Nama	(First, Middle, La	ist)				Death	2. Dete o	Reg. No.		3. Time of Death
Physician	1				Walsh				Month Febru	Dey	Yeer	10:45 PM
/Medical Examiner	An F			ve street end numb				4b. City, Town,	or Location of E		unty of Death	
Examine			lown Creek		104			Texing	on Park	S	. Mary'	g
Funeral	5. Sc	ocial Securify Nur			Age (In yrs.	last birthday)	If Under 1 Yea	r If Under 24		f Birth Dey, Year)		plece (Stete or Foreign intry)
Director		13-42-6135		1□ M 2\\ F	5	57 Yrs.	Months Days	Hours N	Ain. Septen	ber II, 19	941 Was	hington D.C.
hend and			10b. County		10c. City	y, Town or Lo	ocation					10d. Inside City Limits
Mery If sh	Ma	ryland	St. Mary'	S	Iex	kingtan	Park					1 ☐ Yes 2 ☐XNo
fler death with the Mei r Herms 23a or 28a-f's Yner must be notified Funeral Director	10e.	Street end Numb	per	40,000			10f. Zip Coda			10g. Citiza	n of What Cou	untry?
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deat	11.1	Marital Status		12. Was Decede	ent Ever in U,	S. 13.	Was Decedant of If Yes, specify Cui	Hispanic Origin	? (Specify Yes o		Race - Ameri	
o.'.'s	3	☐ Never Married		Armed Force 1 Yes 2 If Yes, Give Year or Dete			1 ☐ Yas 2 🛣 No		иело нісап, асс.		Black, White	ite
"netural",	3		5. Decedent's E	ducation		16e. Dece	dent's Usual Occu	pation		16b. Klnd	of Business/Ir	ndustry
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d other event, I Be C		ether's Neme (F	irst, Middle, Last)				18. Mofher's	Name (First, Mi	ddle, Maiden Su	imeme)	
should be and Mentel and Mentel a		Gregory	Nutha	all				Rose	Kather	ine G	ay	
end end sum	19a	Informent's Nam				19b. Maili	ing Address (Stree	et end Number o	r Rural Route N	umber, City or T	own, Stete, Zi	ip Code)
5 5 5 5	Ka	thleen M	Marie Wa	lsh/Daugl		110 H	East Fort	Ave.,	Baltimo			
100		Method of Dispo		Removal from Sta	20b. P	lace of Dispo emetery, cre	osition (Neme of emetory or other pl	ece)	Date	20c. Loca	tion - City or T	Town, Stata
Pa Intr		4 □ Donation 5			Me	tropol	litan Cre	ematory	2/15/9	9 Alex	andria	, VA
permit. Pag Department Important: I any Injury o once.	21.	Signeture of Fund	eral Service Licer	Age of the sea	1.) N	2. Name and Additatingley	Cardiner				
	23a	Pert1. Enfar the	disease or com	nolicetions that caus	sed the death		P.O. Box 270				-	Approximate
Physician /Medical		shock, of fleat	tallule. List offiy	Ulia causa oli aaci	h line	n. Do not en	iter the mode of dy	ring, such es car	diac or respirate	ny errest,	1	Interval Rehyeen
	dise	ediate Cause (Fi ase or condition atting in death)	inal	. Co	and	iap	ulms	ring, such es car	30		_	Interval Between Onset and Death
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State of Maryland / Department of Health and Mental Hygiene 39

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** 1740 Catherine Zelda WELLER tebruary /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c/County of Death Examiner Washington Washington County Hospital Hagerstown | Hunder 1 Year | If Under 24 Hrs. | 8. Deta of Birth | Month, Day, Year | March 26 1 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** 1 M 2 N F Yrs. Pennsylvania Director 207-03-0483 Usual Rasidance of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Director 1 ☐ Yas 2 No Maryland Washington Williamsport 10f. Zip Coda 10g. Citizen of What Country? 154 N. Artizan Street 21795 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ② No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Navar Married 2 Marriad White by 3 Widowed 4 □ Divorced Completed 16a. Decedant's Usuai Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Dacedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Eiamantary/Secondary (0-12) Collage (1-4or 5+) 8 Manufacturer Seamstress 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middla, Maidan Surnama) Nancy Ellen Shives Bruce Edgar Weller 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Hagerstown, Maryland 21740 Cathy Collins - Niece 9708 Chapelwood Lane 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) 2/9/99 St. Pauls Cemetery Clear Spring, Maryland 22. Nama and Addrass of Facility Minnich Funeral Home 15 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not entar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on each lina. Approximata Intarval Batween Onset and Death CARDIO-RESPIRATORY FAILURE Immediata Causa (Final disaasa or condition rasulting In daath) PUL MONARY EMBOLISM Physician/Medical Examiner Dua to (or as a consequence of) Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaase or injury ATHEROSCLEROTIC CARDIOVASCULAR DISEASE thet Initiated avants rasulting in death) Last HYPERTENSION HEART DISEASE Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? Chronic Renal Failus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🔑 Unknown þ evere Anemia 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death? Completed Gastritis Chronic 1 □ Yas 2 No 25. Wes casa raferred to medical axaminer? Be 26. Placa of Daath (Check only ona) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) Certification: To 1 Yas 2 No 28a. Data of Injury (Month, Day Year) 27. Manner of Daath 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding invastigation 1 ANatural
2 Accidant 1 Yas 2 No 3 Suicida 6 Could not be datarmined 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Plece of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 HomicIde 12 Certifying Physician: To the best of my knowladga, deeth occurred at tha tima, dete end plece, end dua to tha causa(s) end menner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the tima, date and place, and dua to the cause(s) and manner stated. edical 29a. Cartifian 29b. Signature and the of partition 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print)

TANVIR A. VASHA MD 376 MILL STREET HASERSTOWN MD 31. Data filed (Month, Day, Year)

State Registrar

FEB 0 9 1999

32. Registrar's Signatura

Division of Vital Records.

or Attending Physician:

the th

24 hours after death.

within 24 hours after der To the Funeral Director completely filled in by th

show

7 is marked other than "natural", or items 23s or 28s-f shor traumatic event, the Medical Examinar must be notified at

should be filed within 7: ind Mental Hygiena.

1 and 2 should be 1 Haalth and Mental

permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau

Physician

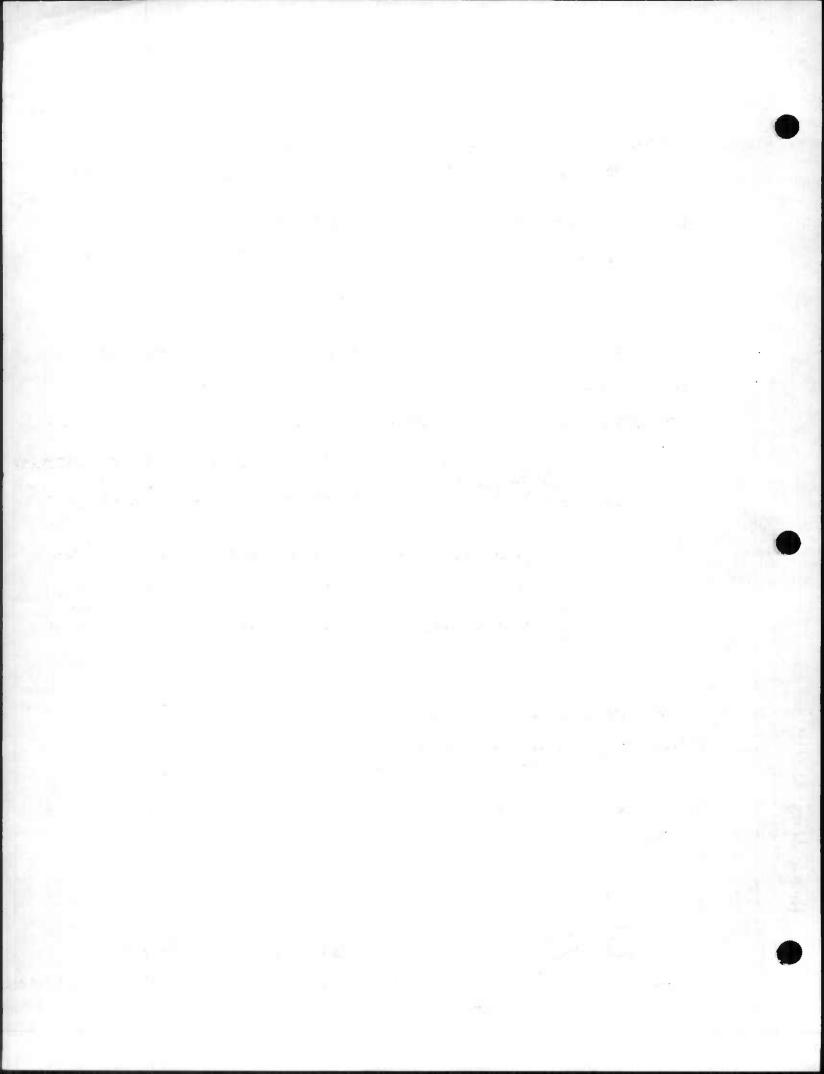
/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

					Certificate	e of L	Death	Re	g. No.			
Physicia		1. Decedent's Name (First, Middle, Las	(1)					Dete of Daath Month	Dey	Yaer	3. Time of De	eth
/Medica		ANNA MARY W	ELLER					BRUARY		999	2:50	A.M.
Examine	er	4e. Fecility Neme (If not institution, give	streat and number)			4	b. City, Town, or Location	on of Deeth	4c. County	of Deeth		
		WASHINGTON COUNT					HAGERSTOW				HINGTON	
Funeral Director		5. Social Security Number 6. Social Security Number 1	ax 7. Age (☐ M 2⊠ F	(In yrs. lest bi 75	Yrs. If Undar Months	1 Yaar Days	Hours Min.	Dete of Birth (Month, Dey, G. 20,	1923	9. Birthp Coun MA	olece (Steta or Fo otry) ARYLAND	oraign
ahow		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Tow	n or Location					1	0d. Inside City L	imits
a or 28a-f ahow Lbe notified at	Director	MARYLAND WASHII	NGTON		10f, Zip		ONSBORO	10	g. Citizen of V	Vhet Coun	1 ☐ Yes 2)	No No
natural, or items 23a or	Funeral Di	18318 LAPPANS ROAL					21713			U	J.S.A.	
el'. o	۵	11. Mentel Stetus 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorcad	12. Wes Decedant Ev Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yaar or Detes:	arın 0,5.	If Yas, spec		spanic Orlgin? (Specify n, Mexican, Puerto Rica Specify:	r res or No- an, etc.)		k, White,	ean Indien, etc. HTE	
natural',	Completed	15. Decedent's Ed (Specify only highest gre-	ucation de completed)	16e	Decedent's Usue	Occupe	etion furing most of working	1	6b. Kind of Bu	siness/Ind	dustry	
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Hyglene. other than ent, the Me	Ö	12			Н	IOMEN	1AKER			HOME	3	
ind Mental Hygi marked other umatic event,	Be	17. Fathar's Nama (First, Middle, Last)					18. Mother's Name (Fil	rst, Middla, M	e <i>iden Sum</i> em	ie)		
markad of	ို	CHARLES WELLER					MARY NAOMI					
0 00 00		19e. Informent's Name/Relationship (7	ype, Print)				and Number or Rural Ro		City or Town,	Stete, Zip	Code)	
of Health if Itam 27 I		WILLA KAAL/NIECE			73 FALLEN			- 1	PENNSY			0
r of		20e. Method of Disposition 1 Burial 2 □ Cramation 3 □	Removel from State	20b. Placa o cemete	of Disposition (Nem ery, cremetory or of	ne of ther plac	e) D	Dete 2	0c. Location -	City or To	wn, Stete	
Y :: 3		4 □ Donetion 5 □ Other (Specify		ST. P	AUL'S CE	METE	RY 2/10)/99 CI	EAR SE	PRING	, MARYL	AND
Departme Importan any injur once.		21. Signature of Funerel Service Vicent	D A 00	1.15/	22. Nama and		s of Facility					1112
8 3 3 5		P. Steven Danf	· 0 1 04m	pen,	BAST F	UNER	A L.Ht IVIB	06 01d				
		23a. Part1. Enter the disease, or companies shock, or heert failure. List only of		death. Do	not enter the mode	e of dyine	BOC g, such es cardiac or re	onsboro	o, Mary	rland	21713 Approximate	-
ysician		shock, or heert failure. List only o	one ceuse on each line.								Approximate fntervel Betwee Onsat and Dear	en ith
Medical		Immediate Cause (Final						0		1	ew,	
xaminer		disease or condition resulting in death)	. DOST - 01	serax	ive aci	ule	mijo cardia	1 unic	irction	L 1	nour	`3
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and I-tra	Xa	Sequentially list conditions, if any, laading to Immediata			consequance of):					i	few	
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attending physician and I for use as the buriel-transi	Physician		d									
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igned by the attendi	by Ph	end stage ren	al fail	ure				1 ☐ Ye		3 Prol	bably 4 ☐ Uni	known
s been signed b	Completed by	end Stage Card	Lovascul	ur de	sease-	non	- reconstru	24e. Wes an	eutopsy ed?	CO	ere eutopsy findi ellable prior to impletion of caus deeth?	_
this certificate has be rel director, page 2 s	EOS		Vascular	ause	Law			1 □ Yes	3/	1[☐Yes 2☐ No	
s certificate director, par	Re	25. Wes case referred to medical examiner?					26. Place of Deeth (C	heck only one)			
S O	9	TU TES ZINO	Hospitel: 1 Inpatient			_	4 Nursing nome				y)	
vath. vr. After t he funere	Certification:	27. Manner of Deeth 1. Neturel 5 Pending 2 Accident investigation	28e. Date of Injury (Month, Dey Y	'ear) 28b.	Time of 28 Injury M	8c. Injury Work 1 □ `	yet (? Yes 2 □ No	Describe how	v injury occuri	red		
within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	ertific	a Diguistide 6 Di Could not be						Location (Stre City or Town,		er or Rura	al Route Number,	
24 hours Funeral stefy fille	edical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	Iner: On the besis of ex	camination er	e, deeth occurred end/or investigetion,	et the tim	e, date end pleca, end pinlon, deeth occurred e	due to the car t the time, da	use(s) end <i>me</i> te end pleca,	enner es si end due to	teted. the ceuse(s)	
within To the comple	-	29b. Signature and title of certifier	end manner stete	u.	29c.	. License	nu <i>m</i> ber	29	d. Dete signe	d (Month,	Dey, Year)	
		14 DTA	_			73	8764		2/9/	34		
		30. Name end address of person who d		th (Item 23e)	(Type, Print)			C. 1.	-		1 /1.	
		Karl P. Rigs 31. Date filed (Month, Dey, Yeer)	2	[[IIIO	Medica	70	impus ed	Juli	100 HO	igers	town Hd	2174
State Registra			32. Registrer's	Significant	19. Se	DOLA	2					

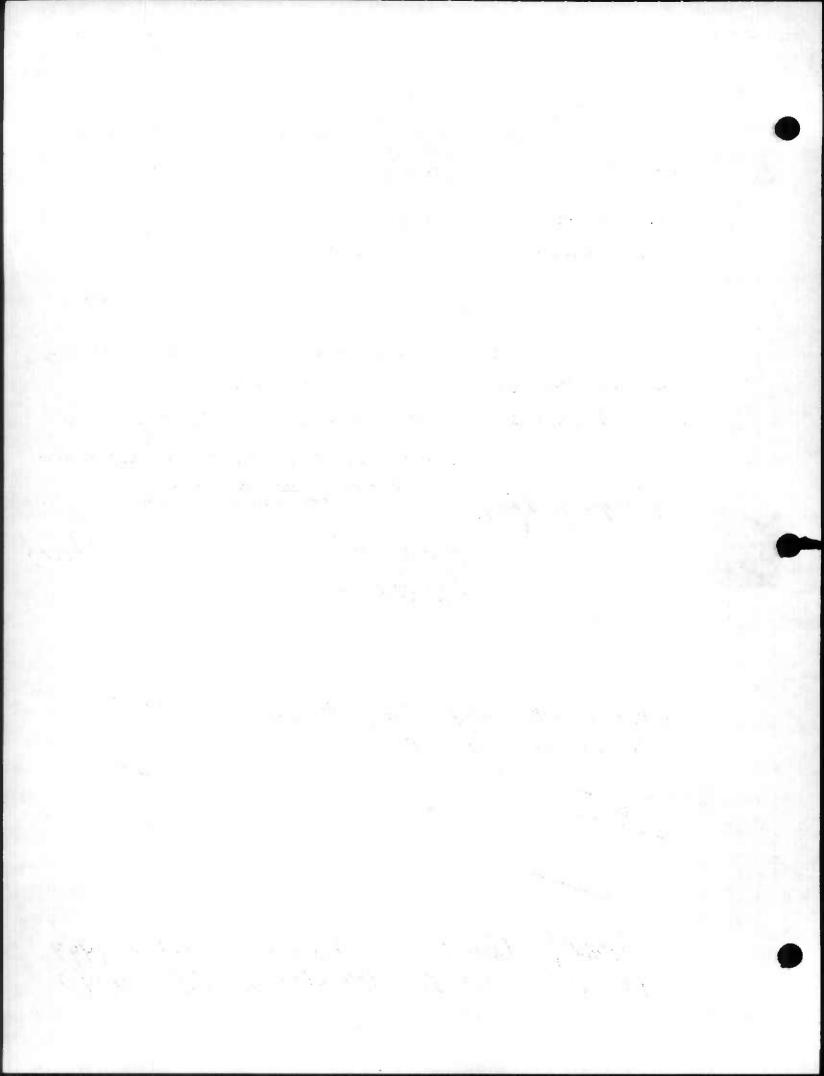
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Physici						Certificate	of Death	F	Reg. No.		
	an	1. Decedent's Neme (First, M						2. Dete of Dee	eth Day	Yeer	3. Time of Dea
/Medic Examin	al	Martha Jane 4e. Facility Neme (If not instite Washington	ution, give stre	et end number			4b. City, Town, or I Hagerstov		4c. County	of Deeth	2220 County
Funeral Director		5. Social Security Number 215–18–1207	6. Sex		ge (In yrs. lest bii	Months D		8. Date of Birth (Month, De) May 12	- /	9. Birthpia	ace (Stete or Fo
		Usual Rasidence of Deceden						Tady 12	1310		7 20210
ehow d at	_	10a. Stete 10b. County 10c. City, Town or Location								10	d. Inside City Li
Me M	ecto		hingtor	1 Co.	Hagers						1 ☐ Yes 2 🕅
23a or 2	Funeral Director	10e. Street end Number 21 Summerlin	Drive			10f. Zip Co. 217			10g. Citizen <i>o</i> f W USA		ry?
or should be filed within 72 hours after death with the Meryland and Mental Hygiene. Its marked other than "natural", or frame 23a or 28a-f ehow aumatic event, the Medical Examinational be notified at	by	11. Meritel Stetus 1 Never Married 2 !! 3 Widowed 4 Divor	Married	Was Decedent Armed Forces' 1 X Yes 2 ☐ If Yas, Give Year or Dates:	5/18/43	13. Was Decedent if Yes, specify (of Hispanic Origin? (S Cuben, Mexican, Puert No Specify:	pecify Yes or No- Pican, etc.)	14. Rece Bleck Specify:	- America k, White, et	
thin 72 hours e. an "naturel", Med cal Exe	Be Completed	15. Dece (Specify only his Elamantary/Secondery (0-1		on ompleted) Collega (1-4or		Decedent's Usuei Od (Give kind of work do iifa. DO NOT use re	ccupetion ona during most of wor tired)		16b. Kind of Bu		
ygien Fr th	Con	12		2		lerical Wo			Federal		rnment
oven	Be	17. Fether's Neme (First, Mid Thomas Roy P		rger			18. Mother's Nan	e Colber		e)	
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end 2 si ealth end n 27 is r		19e. Informant's Name/Relati Annie Otto/Si			2	00 BenSpec	ck Road, He				
permit. Pages 1 end 2 should be filed within Department of Health end Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumetic event, Ire Money.		20e. Method of Disposition 1 → Burial 2 □ Cremeti 4 □ Donetion 5 □ Othe		ovei from State		f Disposition (Name orly, cremetory or other in View Ce		Feb.10	20c. Location - O		
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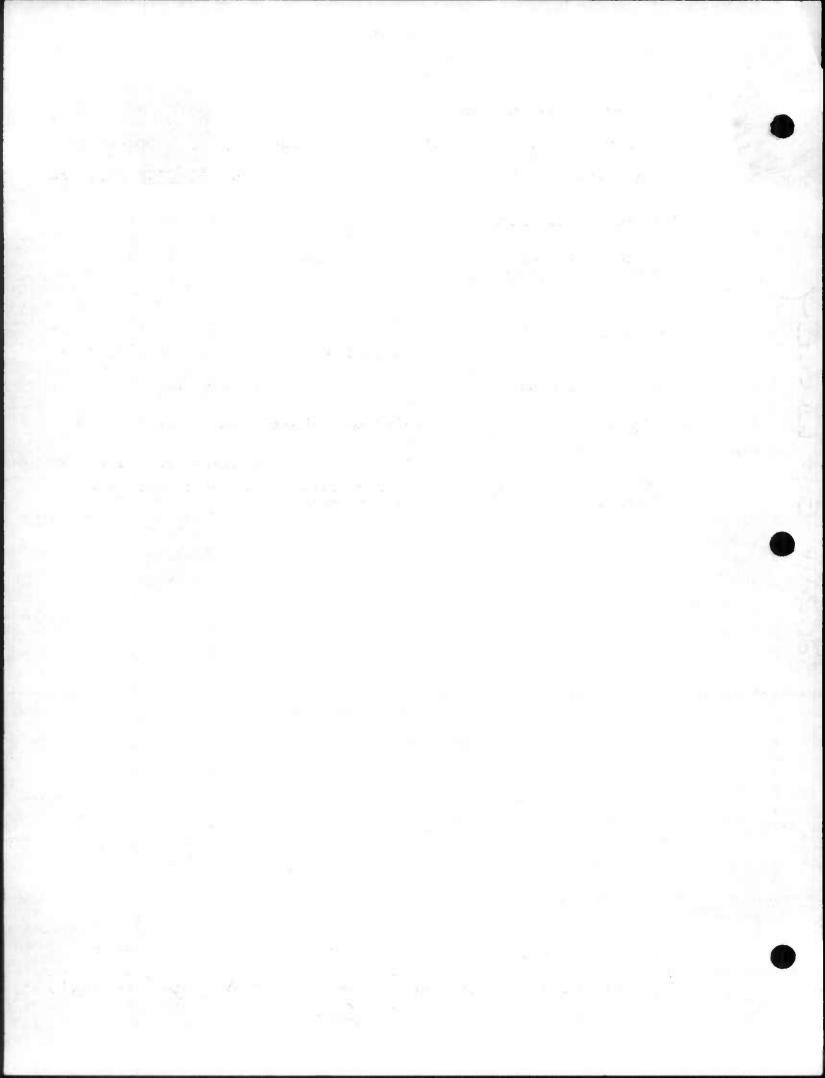
DHMH 16 Rev 6/95



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	Dorcheste						Camb	ridge		rche		
neral ector	5. Sociel Security Number 213–14–179	90 10	J M o M E	e (In yrs. les 83		f Under 1 Yeer lonths Deys	Hours Min.	8. Dete of Birtl (Month, De) July 15	Year) , 1915	9. Birthple Countr Mar	y) ylan	i <i>r Foreig</i> n d
	Usuel Residence of Dece 10e. Stete 10b.	dent County		10c. City.	Town or Locat	ion				10	d. Inside C	the Limite
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To Be Completed by Funeral Director	10e. Street and Number	50201				10f. Zip Code			Og. Citizen of V	Whet Countr	ν?	
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Funeral	11. Marital Stetus 1 □ Never Married 2		12. Wes Decedent I Armed Forces? 1 \(\text{Yes} \) 2 \(\text{N} \)	Ever in U,S.	13. Was	Decedent of H es, specify Cub		Specify Yes or No- to Rican, etc.)	14. Rac	e - America ck, White, et		
þ	3 ☑ Widowed 4 □ D	ivorced	If Yes, Give Yeer or Detes:		1⊔	Yes 212 No	Specify:		Specify	. Wh	ite	
Completed	15. D (Specify onl	ecedent's Edu highest grad	icetion le completed)		16e. Decedent	t's Usuel Occup d of work done	pation during most of wo d)	rking	16b. Kind of Bu	usiness/Indu	stry	
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Be C	17. Fether's Neme (First, i	Middle, Last)					18. Mother's Ne	me (First, Middle,				
ToB	James W.	Robbi	ins				Mi	nnie L.	Hall			
4	19e. informent's Neme/Re	eletionship (T)	/pe, Pnint)		19b. Melling A	Address (Street	and Number or R	ural Route Numbe	r, City or Town,	Stete, Zip (Code)	
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	23a. Part / Enter the dise	List anly o	ications that caused ne cause on each in	the death. e.	Do not enter f	he mode of dyir	ng, such es cardie	c or respiretory ar	est,	1	Approximet	e ween
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edical	Cause (Diseese or Injury thet initieted events resulting in deeth) Last	- 5	C	Due to (or e	s e consequen	ice of):						
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tor	Neturel 5 2 Accident	Pending Investigation	(Month, Day	Year)	Injury	Wor	k? Yes 2 □ No	200. 0000.00	on anjusy coccan	00		
1 Log	3 ☐ Suicide 6 ☐	Could not be determined	28e. Piece of Inju	ry - At home	e, ferm, street,	factory, office		28f. Location (S	treet end Numb	er or Rural	Route Num	ber,
	4 Homicide		building, etc	. (Specify)				City or Tow	n, Stete)			
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Dete of Deeth Month 3. Time of Death **Physician EDWARD** WATERS JANUARY 28 1999 11:40 PM /Medical 4a Fecility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Ber Worce Ster IN SING ome If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yaer) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Months Hours 215-18-4485 Usuel Residence of Decedent M 2 F Yrs. **Director** 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits th end Mental Hygiene. 7 is marked other than "netural", or items 23a or 28a-f ehov traumatic event, tra Medical Evantiner must be nottind at 1 ☐ Yes 2 No WOL Director SNOW 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 33 186 Road Funerai 2 12. Was Decedent Ever in U,S. Armed Forces? Was Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - Amarican Indian, Black, White, etc. 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours effort. Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or item any injury or other traumatic event, the Mental and any injury or other traumatic event, the Mental and any injury or other traumatic event, the Mental and any injury or other traumatic event, the Mental and any injury or other traumatic event, the Mental and any injury or other traumatic event, the Mental and any injury or other traumatic event, the Mental and any injury or other traumatic event, the Mental and any injury or other traumatic event, the Mental and Any injury or other traumatic event, the Mental and Any injury or other traumatic event, the Mental and Any injury or other traumatic event, the Mental and Any injury or other traumatic event, the Mental and Any injury or other traumatic event, the Mental and Any injury or other traumatic event, the Mental and Any injury or other traumatic event, the Mental and Any injury or other traumatic event, the Mental and Any injury or other traumatic event, the Mental and Any injury or other traumatic event, the Mental and Any injury or other traumatic event, the Mental and Any injury or other traumatic event, the Mental and Any injury or other traumatic event, the Mental and Any injury or other traumatic event, the Mental and Any injury or other traumatic event. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Black 3 Widowed 4 Divorced Yeer or Detes: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 10+h aintenance 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Surname Be 0 HENT Henrietta lar 19e. Informent's Name/Reletlor/ship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 20b. Place of Disposition (Neme of cemerery, cremetory or other place) Hill, Md. 2/863 20c. Location - City or Town, Stete NOW Sorah 20a. Method of Disposition Dete 1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) SNOW HILL 22. Namb and Address of Facility Bennie Smith emetary 21. Signature of Funeral Sample Licenses Funeral e, or complications that causad the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast, List only one cause on each line. 23a. Pert1. Enter the disease shock, or heart failure. **Physician** arteriosclerolie Cardiovasculas Dinan /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Examiner physician end s the buriel-transit Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): 8 USB signed by the a Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? ronie Renal Disease; Ess. Hy page 2 Soule Rementia: 1 ☐ Yes 2 ₺ No 1 ☐ Yes 2 1 No 25. Was case refarred to medical examiner? funeral director, Be 26. Piece of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) Hospital: 1 | Inpatient 2 | ER/Outpetiant 3 | DOA To 1 Yas 2 No After this 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: 1 Meturel 5 Pending 2 No 1 ☐ Yes Investigetion 2 Accident 6 Could not be determined 3 ☐ Suicide filled in by

Box 68760 Division of Vital Records, P.O. or Attending Physician: To the Hospital or Attendin within 24 hours efter death. To the Funeral Director: Af

death with the Marylend

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stefe)

29a. Certifier (Check only one) 29b. Signature and title of certifier

GREGORIO

4 Homlcide

🗺 Certifying Phyeiclan: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2 Medical Examinar: On the besis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Dey, Year)

Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)

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State Registrar

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M. BELLOSO, M.D. 5302 CHINABERRY DRIVE, SALISBURY, M.D. (gar) 32. Registrar's Signature

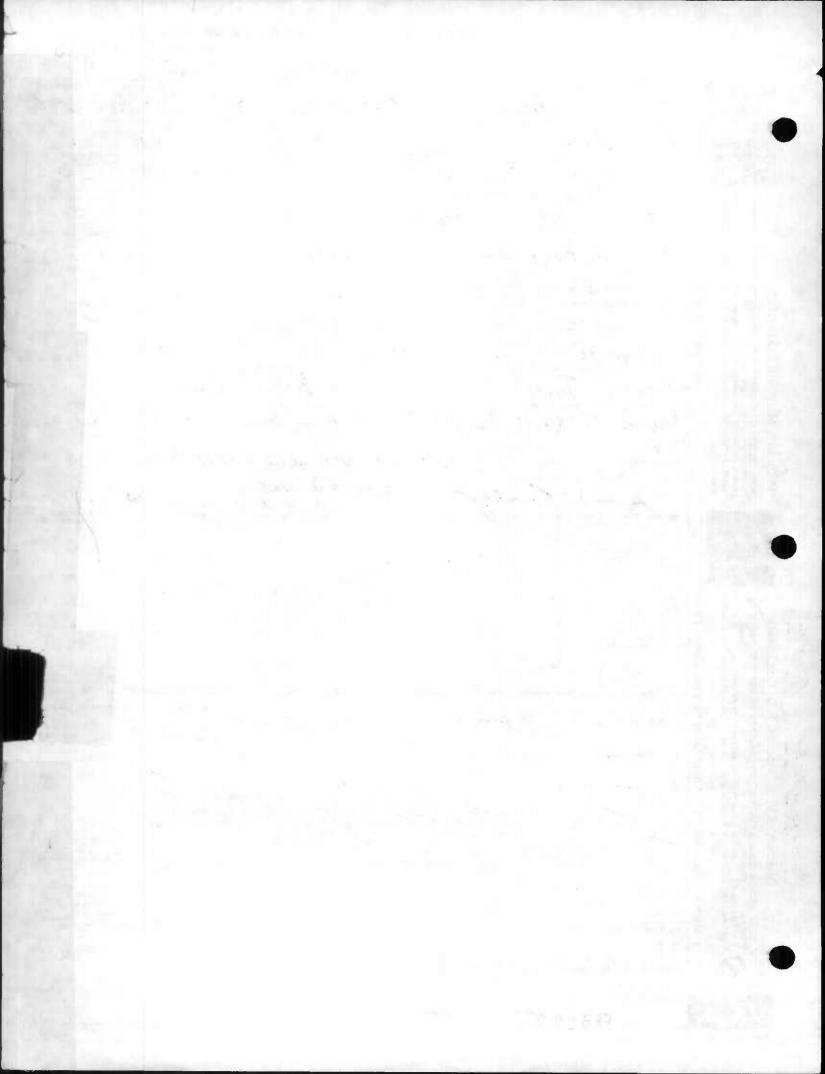
Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygien@ Q Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Deta of Death 3. Time of Death Month 184 **Physician** 00 Am 13 lan Kenshi 1999 relo Inna /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Examiner evindale Baltimore
If Under 1 Year If Under 24 Hrs. 8. Date 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplaca (Stata or Foraign Country) 6 Sex 7. Aga (In yrs. last birthday) **Funeral** Min 1 M 2 F Months Hours Days 219-16-9830 Usual Rasidance of Dacedant Yrs Director 10d. Insida City Limits 10c. City. Town or Location 10a Stete 10b. County Pages 1 and 2 should be filed within 72 hours efter death with the Meryrer nent of Health end Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other treumatic event, the Madical Examine mast be notified at 1 Yas 2 □ No Director Ma 10e. Street end Numba 10f. Zip Coda 10g. Citizan of What Country? 3512 Avenue 21215 ottage Funeral 14. Race - Amarican Indian, 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status Black, Whita, atc. 1 Yas 2 No If Yas, Give Yeer or Datas: 1 Navar Merried 2 Married 1 ☐ Yas 2 (No Baltimore, Maryland 21215-0020 Specify: Specify: Black à 3 Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grada complated) (Giva kind of work dona during most of working life. DO NOT use ratired) College (1-4or 5+) Elementary/Secondary (0-12) ousewite 5th grade 18. Mother's Nama (First, Middle, Maidan Surnama) 17. Fathar's Nama (First, Middla, Last) Be Drury Carter Millian Jon es 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) MC Daughter 35/2 Cottage Baltimore, Hd 21215 Neil Avenue 20b. Placa of Disposition (Nama of camatary, crematory or other placa) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from Stata National Cay 2-23-99 permit. Page Department of Important: If any injury or once. Baltimore 4 □ Donetion 5 □ Othar (Specify) 22. Nama and Addrass of Fecility 21. Signatura of Funarai Sarvica Licensas yarch F. H. West 23a. In th. Enter the disease, or complications that can sed the death. Do not enter the mode of dying, such es cardiac or respiratory arrast, shock, or heart feiture. List only one cause on each line. Balto ped 21215 Walash Avenue Approximeta Intarval Batween Onsat and Death Physician Immediata Causa (Final disaasa or condition resulting in daath) /Medical Cardio-pulmonu **Examiner** Due to (or as a consequence of): Physician/Medical Examine ath enoscionte Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaasa or injury that initiated avants Dua to (or as a consequence of): Due to (or es e consequança of): rasulting in daath) Last Pert II. Other significant conditions contributing to daeth but not resulting in the underlying cause given in Part I. 23h. Did tobacco usa contributa to the cause of been signed by t should be detach 1 Yas 2 No 3 Probably disque ancm1= þ 24b. Ware eutopsy finding eveilable prior to complation of cause of death? 24a. Was en autopsy performed? Completed decibite s certificate has director, page 2 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was case ratarred to medical axaminer? ntumence or Attending Physician: 26. Plece of Deeth (Check only one) Be Hospital: 1□ Yes 20 No Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 0 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 1. Watural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 28f. Location (Straat and Number or Rurel Routa Number, City or Town, State) 6 Could not be datarmined 3 Suicide 28e. Plece of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 | Homicida To the Hospital within 24 hours e. To the Funeral Completely filled Certifying Physician: To the best of my knowladga, daath occurred et tha tima, data and place, and dua to tha causa(s) end menner as statad.

| Medical Examinar: On the basis of examination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to the cause(s) and manner stated. 29e. Certifier Medical 29c. Licanse number 29d. Data signed (Month, Dey, Year) 29b. Signatura and title of certifian 17:4490 7 Consul 30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print) Belvedone 2-121) 31. Data filed (Month, Day, Year) 32. Ragistrar's Signatura State

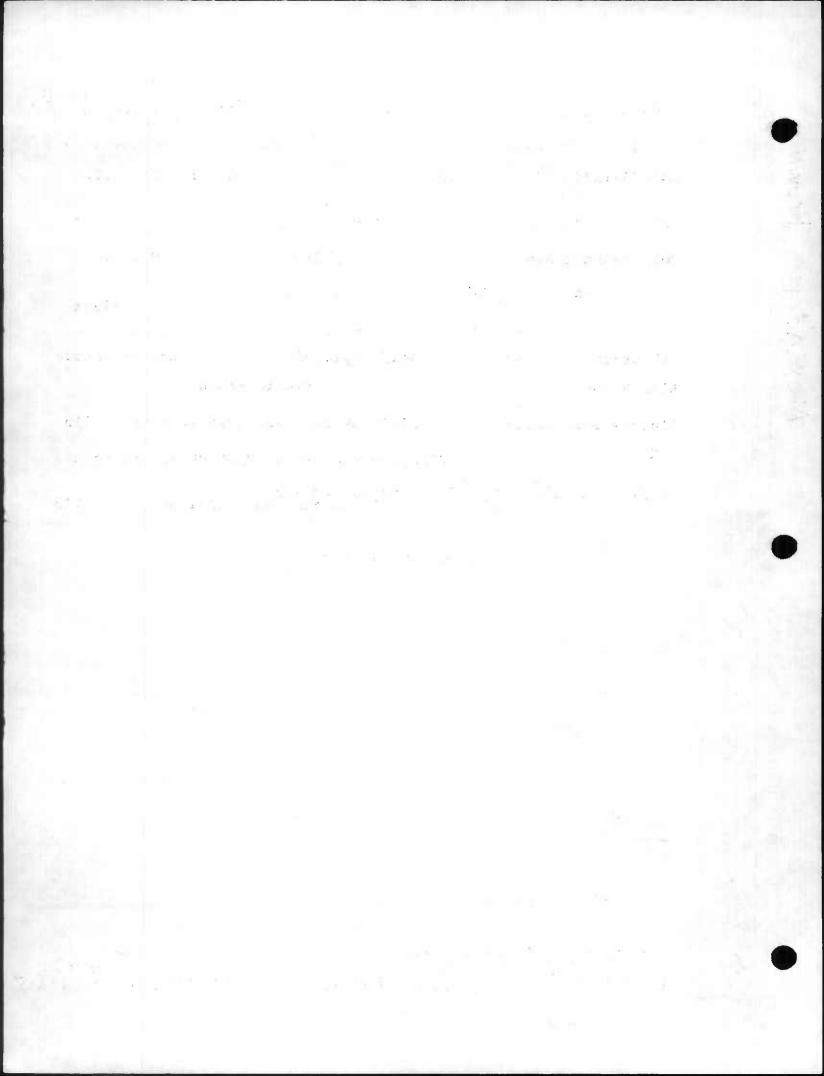
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Registrar

3LAWKENSHIP



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q 64 Certificate of Death 1 Decedent's Name (First Middle Last) 3. Time of Deeth 2. Date of Deeth Month **Physician** February 16, 1999 4c. County of Death Arexander p.M · /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth -Examiner 9. Birthplace (State or Foreign Country) If Under 24 Hrs. Del 4 more 94 Michael 11/4 If Under 1 Year 8. Date of Birth (Month, Day, curity Number 6. Sex 7. Age (In yrs. lest birthday) **Funeral** 1XM 2□ F Deys Min. Year) Yrs. 241-38-1184 Usuel Residence of Decedent Director 67 N.C. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Itema 23s or 28s-1 show other traumetic event, the Medical Examinar must be notified at 1X Yes 2 No Directo MD NA Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of Whet Country? 21215 U.S.A. 3630 Oakmont Ave Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry Elementery/Secondery (0-12) College (1-4or 5+) Grocery Store 7th grade Self Employed 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) and Mantal Alex Brown Minnie Brown 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Pagas 1 and 2 Department of Health Important: If item 27 Florrie Brown-Wife 3630 Oakmont Ave, Baltimore Md altimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete any injury or c 1 Burlat 2 Cremation 3 Removel from State 4 Donetion 5 Other (Specify) King Memorial Park 2/20/99 Randallstown, 21. Signature of Funeral Service Licenses 22. Name end Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel diseese or condition resulting in deeth) /Medical LOULER **Examiner** Due to (or es e consequence of): Physician/Medical Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of) P.O. Box 68760 Due to (or as a consequence ot): 23b. Did tobacco usa contributa to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1. No 3 Probably 4 Unknown Division of Vital Records, b 24b. Were autopsy tindings aveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed Aftar this cartificate has 1 Yes 20 No 1 Yes 2 No 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2☐ No 2 1 Inpatient 2 ER/Outpatient 3 DOA Dete of Injury (Month, Dey Year) Certification: 27. Menner of Death 28c. Injury et Work? 28d. Describe how Injury occurred 1. Netural or Attending 5 Pending investigation daath. 2 No 1 Yes 2 Accident 24 hours after deat 6 Could not be determined 3 ☐ Suicide 28t. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 - Homicide 29e. Certifier 🕊 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner es stated. Medical complataly (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner steted. To the within 2 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Belvedere Ave.)onald Se 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture Registrar **DHMH 16 Rev 6/95**

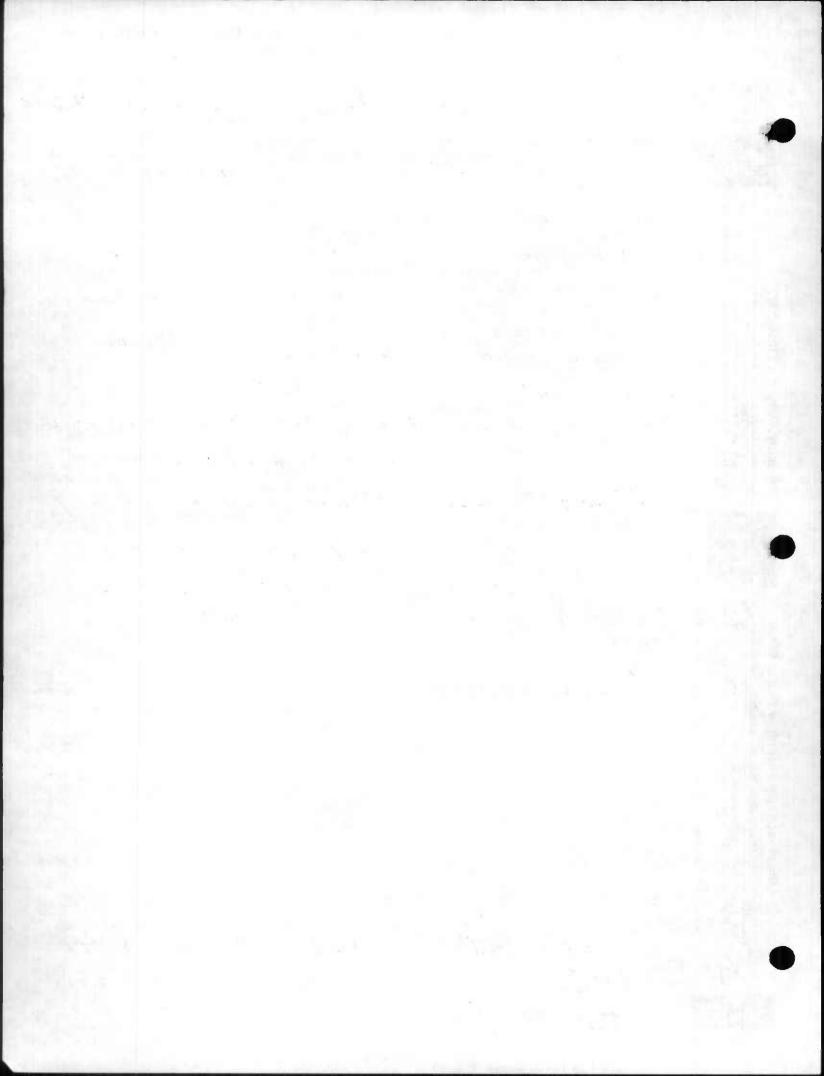


Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 0.506

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month **Physician** 4:50 P.H /Medical 4b. City, Town, or Location of Daath Facility Name (If not institution, giva straat and number 4c. County of Daath Examiner NA Medical Balhmore If Under 24 Hrs. 8. enter 5. Social Security Number 6 Sev 7. Aga (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** 10 M 20 F Min Months Davs Hours -14-4328 Yrs. Director Usual Residence of Decedent with the Marylend 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-fahow traumatic event, the Medical Examiner must be notified at Ves 2□No Baltimore WA Director Ma 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? 21215 Heights 15 Items 23a Funeral Was Decedanf Ever in U,S Armed Forces? 1 Yes 2 W No If Yes, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, Whita, etc. 1 ☐ Never Married 2 ☐ Married Black 1 ☐ Yes 20 No Specify ρΛ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed NA thgrade 17. Father's Name (First, Middla, Last) 18. Mothar's Name (First, Middla, Maldan Sumama) Samuel Hester 19a. Informant's Name/Reletionship (Type, Print) Daughter 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Shrieves Balto, Md 21216 nchester ernice 20a. Method of Disposifion 20b. Place of Disposition (Nama of cematary, cramatory or other) 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Catonsville Md Star Centery 21. Signature of Funaral Service Licensee 22. Name and Address of Facility / 2/215 H. West 23a. Part1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one couse on each line. Balto Md Approximate Interval Between **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last Division of Vital Records. P.O. Box 68760. Physician/Medicai signed by the atte Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No py 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy performed? has 2 No 1 Tes 2 No Hospital or Attending Physician:
 24 hours after death.
 Funerel Director: After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 8 Other (Spacify) 2 1 Yes 2 No 12 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Certification: 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28c. Injury at Work? 1-2 Neturel 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 3 ☐ Suicida 6 Could not be determined 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner es stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely one) To the Y within 2 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23e) (Type, Print) 31. Dete filed (Month, Day, Year) State Registrar

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Marvland / Department of Health and Mental Hygien

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Month **Physician** BLANDON GERMAINE 12:45 AM 4d. County of Deeth FEB RUART /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner redical -1 berte 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthdey) 5. Social Security Number Birthpiece (State or Foreign Country) **Funeral** 34 Months Deys Hours Min 1 □ M 2 € F Yrs. 216-90-8895 Director May 20, 1964 MD Usuei Residence of Decedent the Marylend 10a Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow 7 is marked other than "natural", or items 23a or 28a-f ahor traumatic event, the Mod cal Exacting trust be notified at MD N/A NOWes 2 No Director Balto 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with 533 Lucia Ave 21229 U.S.A. e filed within 72 hours after death to el Hygiene. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: 11. Meritel Stetus Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bieck, White, etc. 1 X Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) 12th N/A unemployed permit. Pages 1 and 2 should be file Department of Health and Mentel Hy, Important: if item 27 is marked othe any injury or other treumatic event, pages. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) 2 Wilbert Blandon Ellen Gilliam 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Ellen M. Kelly 533 Lucia Ave Balto, Md 21229 Dete 20c. Location - City or Town, Stete 20e. Method of Disposition 20b. Pleca of Disposition (Name of cemetery, cremetory or other place) 1 Buriel 2 Cremetion 3 Removel from State Arbutus Mem Pk 2-23-99 Balto, Md 4 ☐ Donetion 5 ☐ Other (Specify) unerel Service Licensee 22. Name end Address of Fecility Betts Funeral Home 1129 N. Caroline St Balto, 21213 23a. Peñ1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardlec or respiretory errest, shock, or heert failure. List only one cause on each line. Approximete Intervei Between Onset end Deeth **Physician** /Medical immediate Ceuse (Finel SEPSIS disease or condition resulting in death) Examiner Examiner ERMINAL AIDS physicien end s the burial-trensit The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of) Box 68760 Physician/Medical Due to (or es e consequence of): 88 ō Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. the signed by t d be datach 1 Yas 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evailable prior to Completed 24a. Wes en autopsy performed? peen completion of cause of deeth? has ne 2 page 1 ☐ Yes 2 € No 1 Yes 2 No certificate Division of Vital or Attending Physician: after deeth. director 25. Was case referred to medical Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Pinpatient 2 ER/Outpetient 3 DOA this After this funeral of Certification: 27. Menner of Deeth 28e. Dete of injury (Month, Dey Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 1 Netural 5 Pending after deeth. Director: Aft 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) in by 4 Homicide n 24 hours aft re Funeral Di pletely filled in Hospital edicai 29e. Certifier 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date and piece, end due to the ceuse(s) end menner es stated. completely (Check only one) 2 Medical Examinar: On the besis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated. To the Within 2 29b. Signeture end title of cartifier 29c. License number 29d. Dete signed (Month, Dey, Year) D19668 1 h : 5 har + 12 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) AVE, Baltimore . MD R.M.SHAH.M.D. 2600 LIDERTY 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State

Registrar **DHMH 16 Rev 6/95**

FEB 2 2 1999

Liver Sills

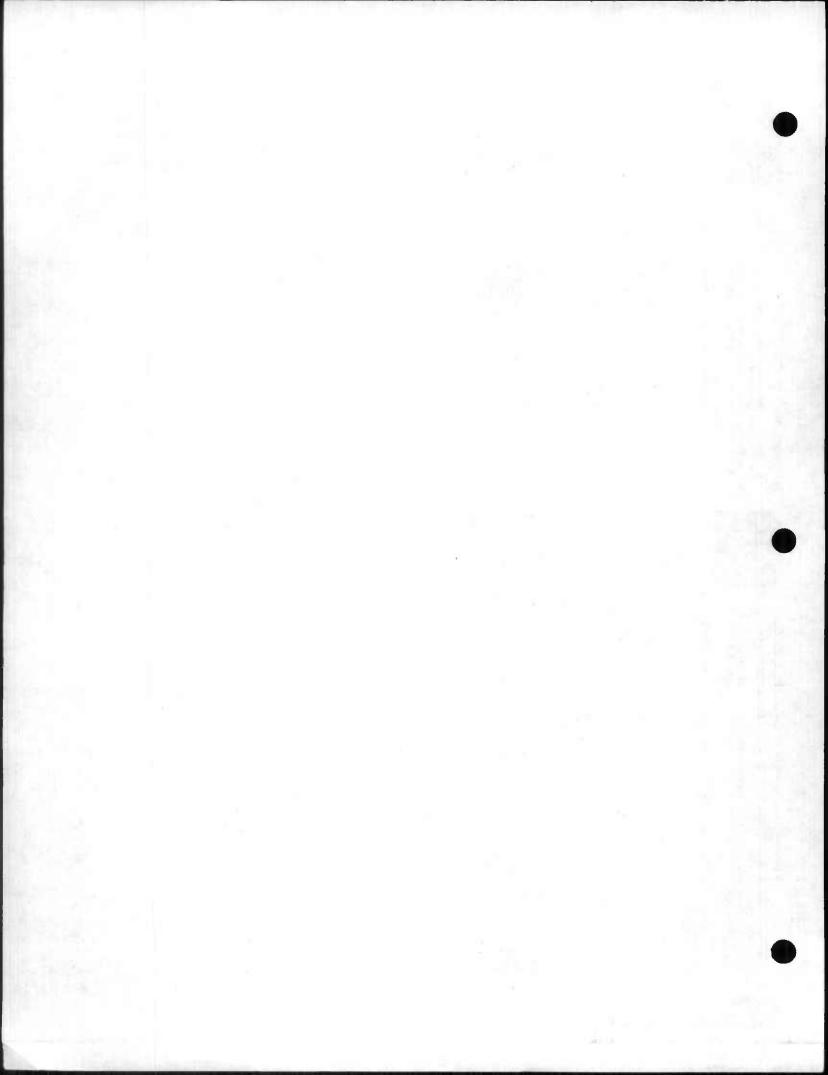
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 0415 **Physician** Burell Vernice E Tes /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore
| Hunder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days 1□M 21 F Months 64 Yrs. Director 212-40-4246 Jul 3, 1934 MD 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits than "natural", or items 23s or 28s-1 show the Medical Examiner must be notified at MD N/A 1 Yes 2 No Balto Director 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2127 Cliftwood Ave 21213 Funeral IJ. S. A.

14. Rece - American Indian,
Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes XXNo Specify: à Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiens. other than "n College (1-4or 5+) Elementery/Secondary (0-12) permit. Pages 1 and 2 should be that w Department of Health and Mental Hygien Important: If Nem 27 is manked other the any injury or other traumetic event. the Domestic 9th Housewife 17. Father's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) 86 Josephine Williams 0 Collins Monroe 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Timothy Burrell 2127 Cliftwood Ave Balto, Md 21213 Date 20c. Location - City or Town, Stele 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 2-25-99 Glen Burnie, Md Cedar HIII Cem 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Betts Funeral Home 1129 N. Caroline st Balto, Md 21213 MILA 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical 15 200 Immediate Ceuse (Finel Cardiopulmenony disease or condition resulting in death) Examiner Due to (or es a consequence of) Examiner metastate Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last and Due to (or es e consequence of): physician s the burial Box 68760. Physician/Medical Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by to 1 Yes 2 No 3 Probably 4 Unknown A retusion þ mellitue 24a. Was an autopsy performed? 24b. Were eutopsy findings evailable prior to completion of cause of death? Completed Eng Trent systemic Lugare 1 Yes 20 No 1 Tyes 2 No. certificate Division of Vital al or Attending Physicien: The sefter death.

I Director: After this certificated in by the funeral director, pages. Be 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Hospital or
 24 hours eft
 Funeral Directly filled in 29a. Certifier Medical 120 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) and menner as steted. To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture end title of certifier 29d. Date signed (Month, Day, Year) Au4176 43579364 myen 30. Name end address of person who complet cause of death (Item 23a) (Type, Print) 105 E. Voir. Yarkwa t'usere wian la ne [tvs ital (00 Batherine mo 21218 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature State Registrar FEB 2 2 1999 **DHMH 16 Rev 6/95**

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death FEBRUARY Dey 8:05 Am Charles, W, Bussler 19 1999 4a Facility Name (If not institution, give street and number) 4b. City, Town or Location of Deeth 4c. County of Reet ARUNDEL GLEN ANNE BURNIE RUNDEL HOSTITAL NORTH | Hunder 1 Year | Hunder 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | Aug. 13, 1930 9. Brithplece (State or Foreign Country) Maryland 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) 212-28-2803 Yrs. Usual Residence of Decedent 10a. State 10b. County t Oc. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zin Code t 0g. Citizen of Whet Country? 1313 Williams Street 21061 United States 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Amarican Indien, 11. Marital Status Bleck, White, etc. Armed Forces? 1 △ Yes 2 □ No If Yes, Give Year or Dates: 1948- '50 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) t 6b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Postal Worker 12 U.S. Postal Service 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Charles L. Bassler Vivian Nash 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold Bassler/ Son 2675 Avalon Ct., Alexandria, Virginia 22314 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Feb. 20 20c. Location - City or Town, State 1 ☐ B\rial 2 SCremation 3 ☐ Removal from State Metro Crematory, Inc. 1999 Catonsville, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility n of Futneral Sarbine Licenses Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) Respiratory failure 1-2days 1 wonth Pacyno thorax Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Plewal eff.wsm Due to (of \$6 a consequence of): man Mrs unths-years renal 1954 Hiems Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ingulia dependent dichetes mellitus 24b. Were autopsy findings eveilable prior to completion of causa of death? 24a. Was en autopsy performed? Hypertensian 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2000 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1/29 Appatient 2 ER/Outpatient 3 DOA

28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29d. Date signed (Month, Dey, Year)

Physician /Medical Examiner

permit. Peges 1 and 2 should be filed within 72 Department of Heelth and Mental Hygiene. Important: if from 27 is marked other than "naturally or other treumatic event than "naturally and page."

BASSLER,

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or hame 23s or 28s-f show the Medical Examiner must be notified at

Directo

P

Completed

Examiner Physician/Medical Completed 8 this After this Certification:

Box 68760 Division of Vital Records, P.O. To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After ti completely filled in by the funera

> State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year)

5 Pending investigation

6 Could not be

27. Manner of Death

t Natural

2 Accident

4 ☐ Homicide

3 Suicide

29a. Certifier (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 203 Hospital DI We # 202 Glen Burnie, MD 21061 John F.W. Yer MD 32. Registrar's Signature

28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

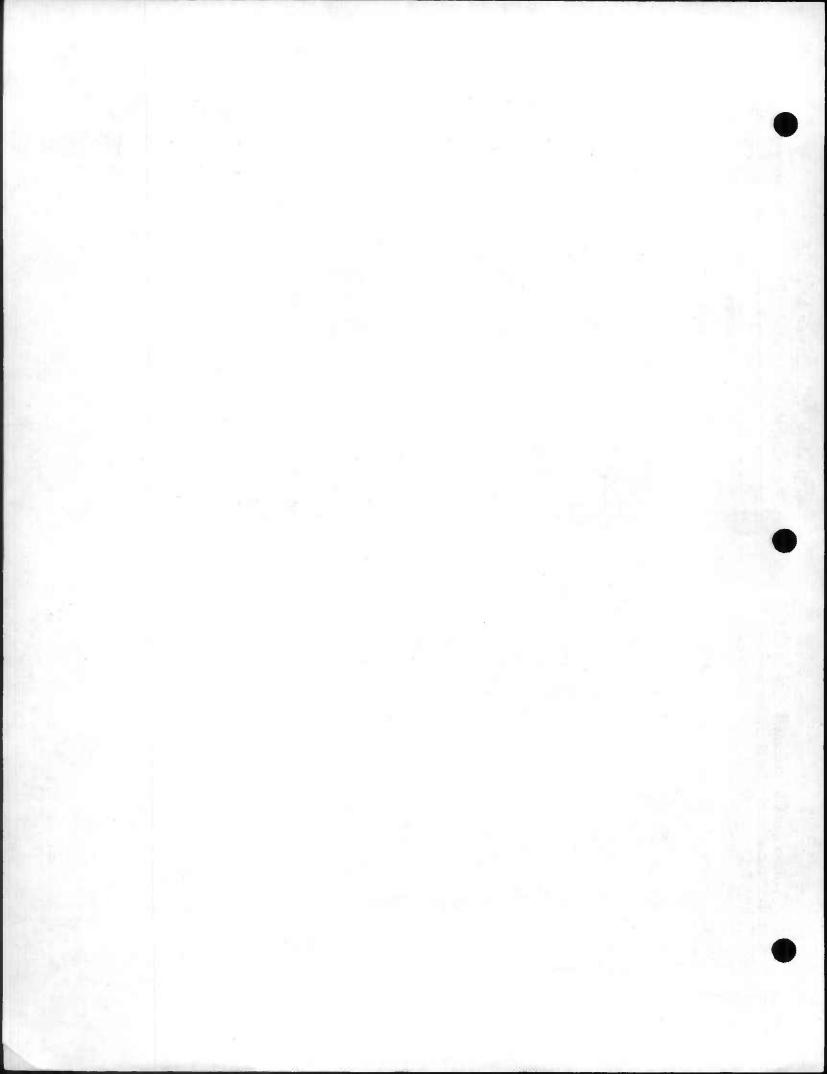
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

t ☐ Yes 2 ☐ No

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Carrie Aline Bortner 20, 1999 4c. County of Death Feb. 11:40 p.m. /Medical 4e Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Manchester

| Manchester | Min. | Month, Day, Year) | Months | Days | Hours | Min. | May 20, 19 Long View Nursing Home Carroll 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 10 M 20 F O Yrs. Director 219-30-2261 Finksburg. Usual Residence of Deceden the Maryland 10a. Stete 10b. County 10c City Town or Location 10d. Insida City Limits 7 is marked other than "natural", or itema 23a or 28a-f ahow traumatic event, the Medical Examiner must be notified at Carroll Md. Westminster No Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Church St. U.S.A. Apt. 2 21157 Funeral death 12. Was Decedent Ever in U,S.
Armed Forces?
1 Yes, 2 Ano
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Black, White, etc. 1 Never Married 2F Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: À 3 Widowed 4 Divorced "natural", White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: if fem 27 is marked other than in eny injury or other traumatic avant Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Homemaking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles A. Sullivan Adaline Haines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 21157 Miles Burnell Bortner-7 N. Church St. Apt.2 Westminster, Md. husband 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Feb. 23. 1999 Baltimore, Md. 22 Name and Address of Facility
Eckhardt Funeral Chapel 21. Signature of Funeral Service License 3296 Charmil Dr. Manchester. Md. 21102 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart failure. List only one cause on each line. Approximate Intarval Batween Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examine nocarcinomo attending physician and for use as the bunal-transit Sequentially list conditions, if any, leading to immediata causa. Entar Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of) Box 68760 Physician/Medicai that initiated events rasulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? Completed Deen : certificate has 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical exeminer? Be 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 2 Hospital or Attending Physical St. Hours after death.
 Funerel Director: After this. 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Tima of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending Investigation 1 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the 29b. Signature and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed sause of death (Item 23a) (Type, Print)

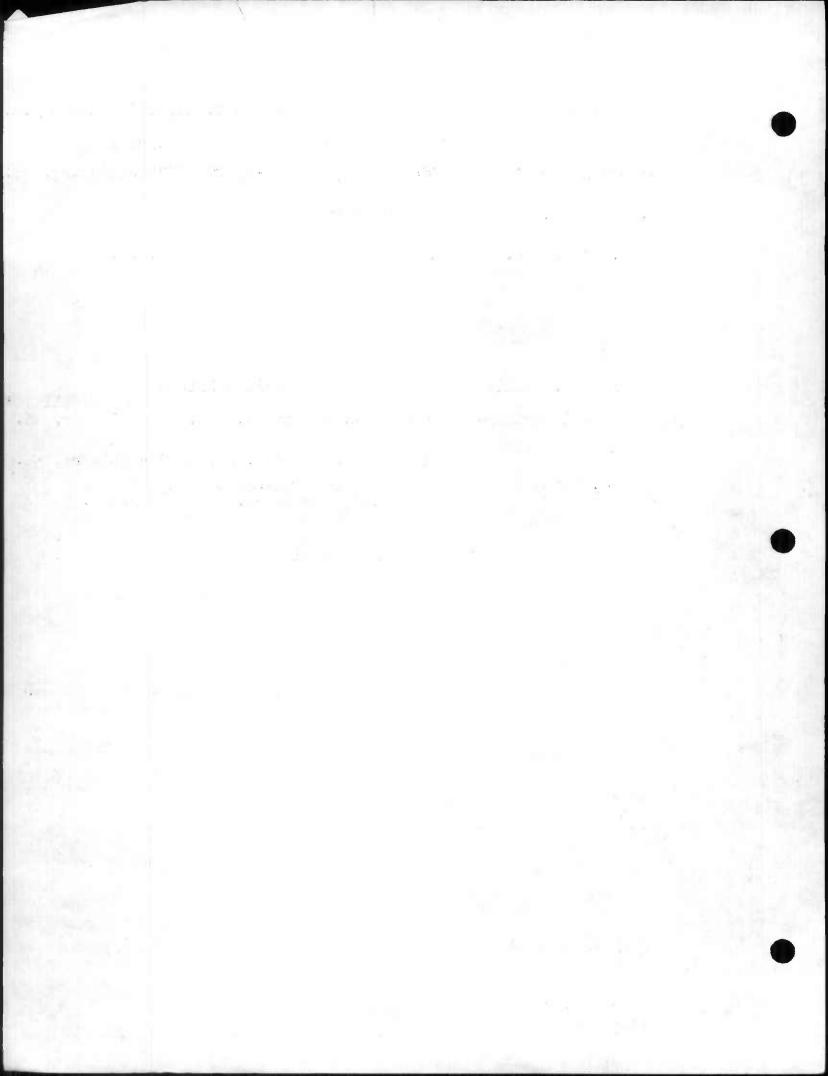
State Registrar

31. Date filed (Month, Day, Year)

Westmuster

Dr.IVe

32. Registrer's Signetyre



TAVON BATTLE		77/98/97	Mental Hygien	Reg. No.				
	sician edical	1. Decedent's Name (First, Middle, I	TYRONE	BAT	TLE		Day Year 15,1999	3. Time of Death 3:03P.M.
	miner	4a Facility Name (If not institution, g		tc. County of Death	10			
		SHOCK TRAUMA CEN 5. Social Security Number 6.	TER Sex 7. Age (In yrs.	last birthday) If Under 1 Yea	BALTIMO	s. 8. Date of Birth	9. Birth	place (State or Foreign
Fune Direct		215-96-5887 Usual Residence of Decedent	1X M 2□ F	Yrs. Months Day	rs Hours Mir	FEB, 12,	1981 MA	nplace (State or Foreign Intry) RY LAND
hours effer death with the Maryland ural; or items 23a or 28a-f show	tor	10a. State 10b. County	10c. Cit	, Town or Location BAIT	IMORE	(1,7)		10d. fnside City Limits 1 XYes 2 No
th the	Director	10e. Street and Number		10f. Zip Code		109.0	Citizen of What Co	untry?
23a c	aiD	131 WEST C	ROSS STRE	EET	212	30	USA	,
ter dea	Funeral	11. Maritel Status	12. Wes Decedent Ever in U, Armed Forces?	S. 13. Was Decedent o	f Hispanic Origin? (uban, Mexicen, Pue	Specify Yes or No- rto Ricen, etc.)	14. Race - Amer Bleck, White	
d within 72 hours eft jiene. r than "netural", or i	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🐧 No If Yes, Give Yeer or Dates:	1□ Yes 2/AN	lo Specify:		Specify: R	ACK
72 ho	pete	15. Decedent's (Specify only highest of		16a. Decedant's Usual Occ	cupation ne during most of we	orking 16b.	Kind of Business/	ndustry
within ene. then	Completed	Elemantary/Secondary (0-12)	Collaga (1-4or 5+)	(Give kind of work dor life. DO NOT use reti			NIA	2
filed v Hygie fither t		17. Fether's Neme (First, Middle, La.	st)	NEVER E	18. Mother's Na	me (First, Middle, Maid		1
Alental rked o	and Mental H Is marked oth aumatic even To Be	BIOSS	BAT	TLE JR.	DESS	SIE	RHU	F
and N		19a. Informant's Name/Relationship		19b. Mailing Address (Stre			y or Town, State, 2	ip Code)
and and and and and and and and and and		DAISY RHUE (GRANDMOTHER		SS STREET	T, BALTIMO		
If the		20a. Method of Disposition Burial 2 Cramation 3	□Removal from State	lece of Disposition (Nama of emetery, crematory or other p			Location - City or	
Amit. Peges 1 Separtment of Hemportant: If Item		4 Donation 5 Other (Special Signature of Funaral Service Lie		EDAR HILL CO	EMETERY	02-19-99 GI	ENBU	ENIE, MO
permit. P Departm Importar	DUC		H	JOSEP	H H. BA	ROWN JR.	FUNERA	LHOME
		23a. Part T. Enter the disease, or co	mplications that coused the deat	n. Do not enter the mode of d	tying, such es cerdia	AVE. BA ac or respiratory arrest,	LTIMBRE	Approximata
Physicia	an	shock, or haart failure. List on	ly one cause on aach lina.					Intarval Batween Onsat and Death
/Medic		Immediate Cause (Final disease or condition	Mul	tiple 1	Muri	es		
LXaiiiii		rasulting in death)	Due to (c	r as a consequence of):]	
B1 7	xamine		Bus 4s 4s					
W. F		Sequentially list conditions, if any, laading to immediata ceusa. Entar Underlying	Due to (o	r as a consequence of):				
icata be physician s the buria	ca	Cause (Disease or Injury that initieted events	cDue to (o	r as a consequence of):				
aath certificata attending phys	Physician/Medical	resulting in death) Last	d					
atter	iciar	Part II. Other significant conditions	contributing to death but not res	ulting in the underlying cause	given in Part f.	23b. Dfd tobac	co use contribute	to the cause of death
0 54	Phys					1 🗆 Yes	30 No 3□ P	obably 4 Unknow
ta b	þ					24a. Was an au	1 24h 1	Vera autopsy findings
gned be de						performed	?	available prior to completion of ceuse of death?
requiras tha been signed should be del	ete					1 Aryas	2 No	A
e law requiras that hes been signed to 2 should be det	omplete					7.43		VIN Ves 2 No
The law requiras thatate hes been signed page 2 should be def	Comp	25. Was cese referred to medical			26. Place of De	eath (Check only one)		Yes 2□ No
cien: The law requires tha entificate hes been signed ector, page 2 should be del	ro Be Comp		Hospital: 1 ☐ Inpatient 20	EH/Outpatient 3 DOA	Other: 4 Nursing	eath (Check only one) Home 5 Residence	6 ☐Other (Spec	1
Physician: The law requiras that this certificate hes been signed and director, page 2 should be delined to the control of the certificate hes beautificate the certificate her second the certificate her cer	To Be Comp	25. Was cese referred to medicel examiner? 1 X Yas 2 No 27. Manner of Death 1 Naturel 5 Pending	28a. Date of Injury (Month. Day Year)	28b. Time of Injury 28c. In	Other: 4 Nursing		july occurred	1
Aing Physicien: The law requires than the Affer this certificate hes been signed funeral director, page 2 should be del	tion: To Be Comp	25. Was cese referred to medicel examiner? 1 Yas 2 No 27. Manner of Death 1 Naturel 5 Pending investigat 3 Suicide 6 Could not	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M 1	Other: 4 Nursing	Home 5 Residence	t by a	red bus
Ming Physician: The law requiras than har Affer this certificate hes been signed funeral director, page 2 should be del	tion: To Be Comp	25. Was cese referred to medicel examiner? 1 X Yas 2 No 27. Manner of Death 1 Naturel 5 Pending investigat	28a. Date of Injury (Month, Day Year)	28b. Time of linjury M 1	Other: 4 Nursing	Home 5 ☐ Residence	L by a	bus
Jing Physicien: The law requires than the Affer this certificate hes been signed funeral director, page 2 should be del	tion: To Be Comp	25. Was cese referred to medicel examiner? 1 X Yas 2 No 27. Manner of Death 1 Naturel 5 Pending investigat 3 Suicide 6 Could not determine	28a. Date of Injury (Month, Day Year) 28e Place of Injury - At he building, etc. (Specifi	28b. Time of lipiury M 28c. Ir V 1 28c. Ir	Other: 4 Nursing	Home 5 Residence 28d. Describe how ir 28f. Location (Street City or Jown, St.	and Number or Ruate) (a) A manner as	Cify) Led Low Sural Route Number, Stated.
or Attending Physician: The law requiras tha after death. The law requires tha after continuate has been signed in by the funeral director, page 2 should be delin by the funeral director, page 2 should be delin the continuate of the continuate o	tion: To Be Comp	25. Was cese referred to medicel examiner? 1 X Yas 2 No 27. Manner of Death 1 Naturel 5 Pending investigat 3 Suicide 6 Could not determine	28a. Date of Injury (infonth. Day Year) 28e Place of Injury - At he building, etc. (Specif	28b. Time of 28c. Ir Night of 28c. Ir Ni	Other: 4 Nursing	And the total at the course of the time.	and Number or Ruate) (a) A manner as	cify) Led Stral Route Number, stated. to the causa(s)

State

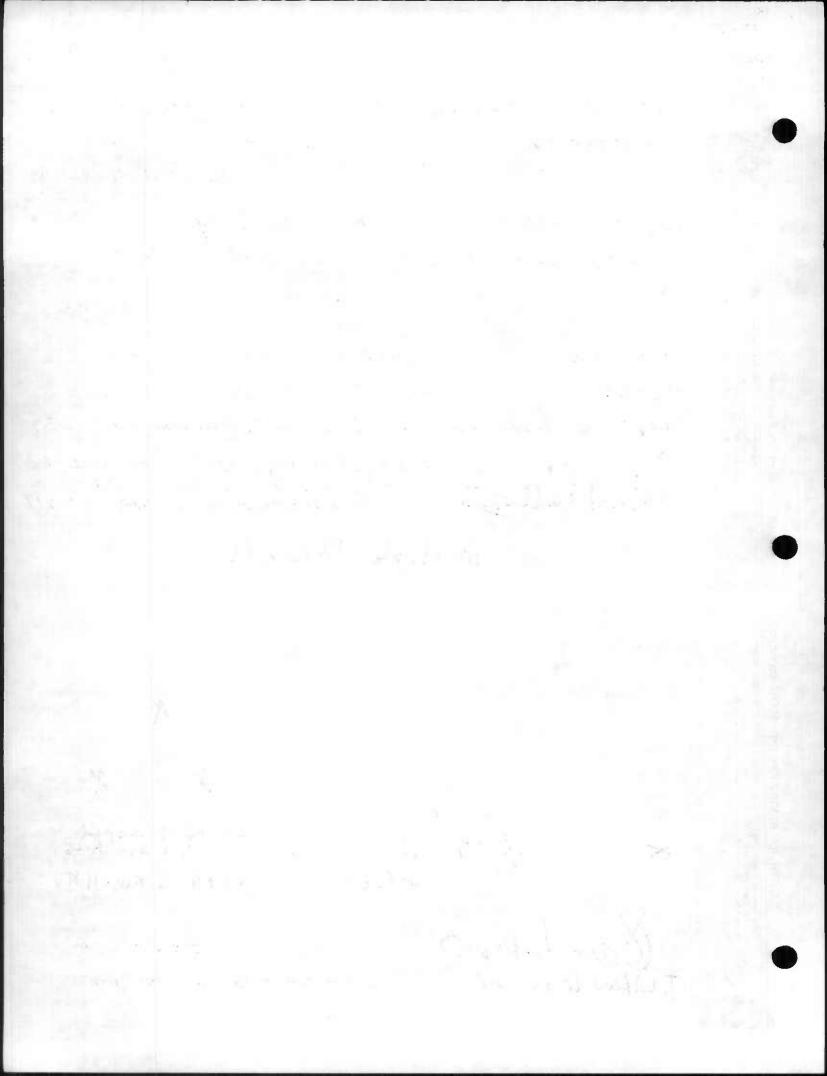
Registrar

ress of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature FEB 2 2 1999

FEBRUARY 16,1999

O.C.M.E.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Bergner February 1999 7:05 AM Thei 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Death Baltimore Baltimore Hospital Good Samaritan Hours Min. 8. Date of Birth (Month, Dey, Y 8/3/1908 Birthplece (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 M 2 F Months Deys Yrs. 212-40-4989 90 Maryland Usuel Rasidence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A Baltimore 1 XYes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4139 Maex Avenue 21206 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Reca - American Indian 11 Maritel Stetus Black, White, etc. 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Married 2 Merried 1 ☐ Yes 2 ☐ No Specify: White 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Collega (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Neme (First, Middle, Maldan Surneme) 17. Fether's Neme (First, Middle, Last) John F. Bergner Irene Jessup 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stata, Zip Coda) 19e. Informent's Name/Ralationship (Type, Print) Walter H. Bergner/Brother 4139 Marx Avenue Baltimore, Maryland 21206 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 2/22/99 Baltimore, Maryland Moreland Memorial 4 ☐ Donetion 5 ☐ Other (Specify) John C. Miller Inc. 22. Neme and Address of Fecility 6415 Belair Road Baltimore, Maryland 21206 thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, use on aech line. 23a. Part1. Entar the disaasa, or complication shock, or heart failure. List only conscault Approximete fnterval Batween Onset and Deeth Myocardia Infarction Immediata Causa (Finel disaase or condition rasulting in daath) 2 days Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Causa (Disaasa or Injury that initiated evants resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of daath? 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case raferred to medical examiner? 26. Place of Death (Check only ona) Hospital: 1 Yas 2 No Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 SInpatiant 2 ER/Outpatiant 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Manger of Deeth 28d. Dascribe how Injury occurred 28b Time of 28c. Injury at Work? 1 Meturel 5 Pending 1 ☐ Yas 2 ☐ No Investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28a. Plece of Injury - At homa, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1 Certifying Physician: To tha best of my knowledga, daeth occurred at tha tima, deta end plece, end due to the causa(s) end mannar es steted.

The lew requires that the death certificate be executed es the buriel ate hes been signed by the ettending physician, page 2 should be deteched for use es the buriel Box 68760. P.O. Division of Vital Records. To the Hospital or Attending Physician: The law within 24 hours effer death.

To the Funeral Director: Affer this certificate has I funeral filled in by completely

Physician

/Medical

MD

Director

Funeral

þ

Completed

Examiner

Funeral

Director

Item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, it a Medical Examiner must be notified at

permit. Peges 1 and 2 sh Department of Health end Important: If them 27 is m any injury or other traum

Physician

/Medical

Examiner

Physiclan/Medical Examiner

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Certification: To

Medical

(Check only one)

29b. Signeture end fifth of certifier

2 should be filed within 72 hours efter deathend Mental Hygiene.

Maryland 21215-0020

with the Meryland

Attending physician

south

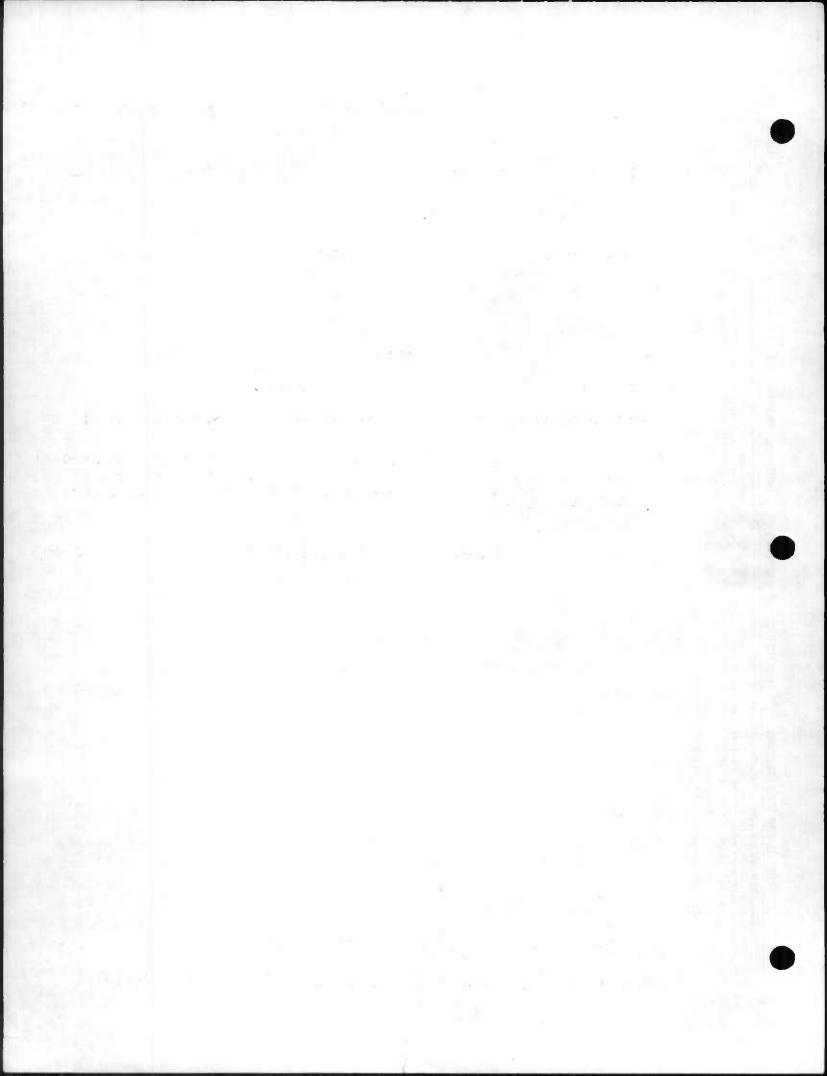
2 Medical Examiner: On the basis of examinetion and/or investigation, In my opinion, death occurred et tha time, data and place, and due to the ceusa(s) and menner steted.

29d. Dete signed (Month, Dey, Year)

February 17 1999

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)
XIAU M ZHOU 5601. LOCH RCIVEN BOWLEVERD. Baltimore MD. 21239 32. Registrar's Signature

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year **Physician** 0130 EGRL Coleman 02 99 16 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner University of Maryland Medical Center Baltimore If Under 24 Hrs. Hours | Min. 7. Age (In yrs. last birthday) If Under 1 Year 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign
Country) **Funeral** Days Months 12 M 20 F Yrs. 217.20.8828A JAN. 11, 1927 Director MARYLAND Usual Residence of Deceden 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director N/A BALTIMORE MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 2 U. S. A. Stephens Ct Saint Apt. ID 21216 death Funeral Herne 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Poloss.

1 Ø Yes 2 No
If Yes, Give
Yeer or Detes: 2 Nov. 1945 hours after 1 Never Married 2 Married natural, or Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☑ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry el Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) KEALT Assistant Property MANAGER filed 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Peges 1 and 2 should be lift Department of Heelth and Mentel Hy Important: if item 27 is marked oth any injury or other traumatic event pobes. Be CLARENCE COLEMAN EMMA LOUISE BAKER 19a. Informent's Name/Relationship (Type, Print) DAUGHTER 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2405 HARLEM AVENUE BALtimore Haryland 21216 MARITIA C. Coleman Dukes 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Feb 23,1999 Owings Mills 4 ☐ Donetion 5 ☐ Other (Specify) GARRISON FORREST 22. Name and Address of Facility
RONALD A. GRAYSON FUNERAL SERVICE 21. Signeture of Funerel Service Licensee Ronalda 8312 Liberty Road Baltimore Moryland Trayson 21244 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediata Ceusa (Final 2 hours CARDIAC ARRYTHMIA disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in deeth) Lest Due to (or es a consequence of): P.O. Box 68760 Physician/Medical physi Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 2 1 ☐ Yes 2 ☐ No signed b Records, p 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy Completed 1 Yes 2 No 1 ☐ Yes 2 X No certificate Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 Anpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? To the Hospital or Attending Privithin 24 hours after death.
To the Funeral Director: After it completely filled in by the funere After 5 Panding investigetion 1 Netural 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ HomicIde 29a. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated. edical (Check only one) 2 Medical Examiner: On the basis of examinetion and/or Investigation, in my opinion, deeth occurred at the time, date and plece, end due to the cause(s) end manner steted. 29b. Signature end title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 99

DHMH 16 Rev 6/95

State

Registrar

31. Data filed (Month, Day, Year)

FEB 2

32. Registrar's Signeture

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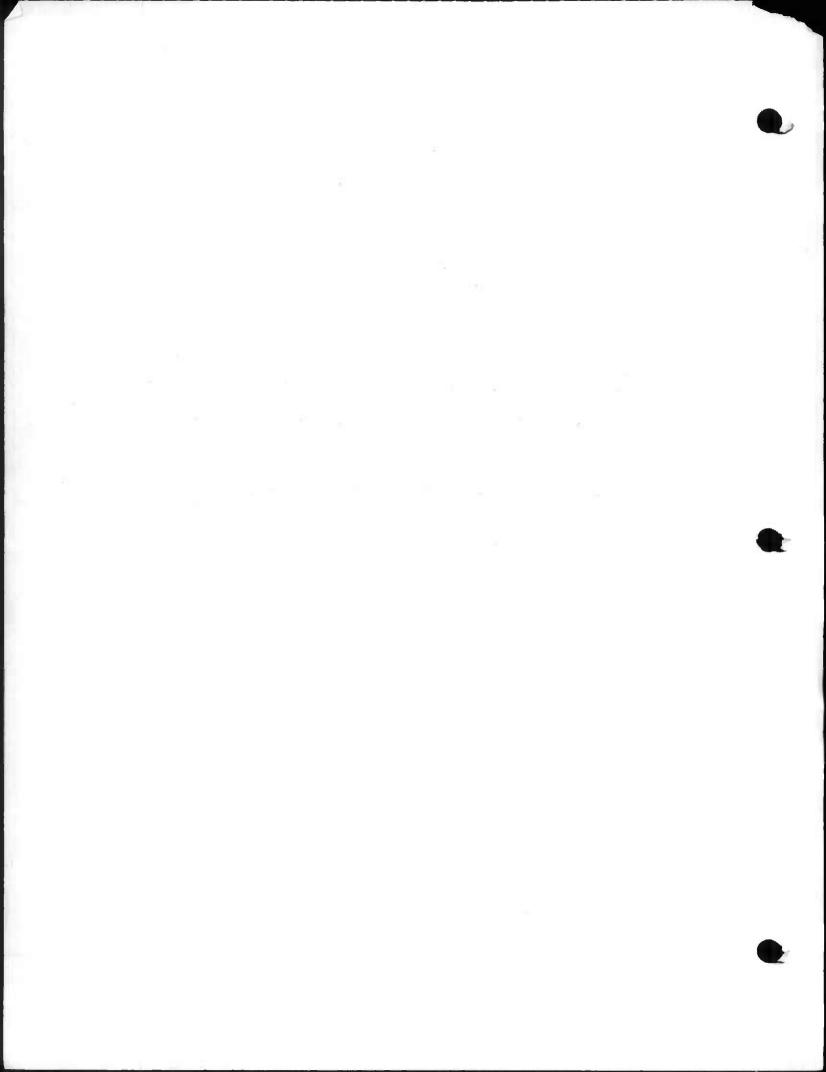
28 Item

permit. Pages 1, 2, 3 should

funeral director, page 5 should be detached for use as the burtal-transit death. to bunal, cremation, or removed hours after mithin below has been signed by the attending physician Dept. of Health and Mental Hygiene prior to requires that the death certificate DR ATTENDING PHYSICIAN: The law After this certificate death with the State DIRECTOR: A hours after di TO THE HOSPITAL
TO THE FUNERAL (
be filed within 72 h
IMPORTANT: If II

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR ITEM: #11 PER INFORMANT G7/3 CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH HARRY FEBRUARY 18, 1999 COOPER 2.10 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 08-06-06 IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 717-07-5456 92 M D X X M 2 - F 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Future Care Nursing Home Baltimore NA RESIDENCE OF DECEDENT 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY MD NA Baltimore 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 524 N. 11. MARITAL STATUS Charles Street Apt. #1013 21201 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? ★ YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No- RACE — American Indian, Black, White, atc. If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 TES 2 NO Specify: Black Specify: ВУ 3 Widowed 4 Divorced COMPLETED 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Trackman Pennsylvania Railroad 3rd Grade NA 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ouickley Joshua Benjamin Cooper Emma 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21206 19e. INFORMANT'S NAME (Type/Print) 2 4107 Ardley Avenue Baltimore, Maryland Gloria Armstead 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, Stata 4 Donation 5 Other (Specify) Pk. Cem. 02-23+99 Randallstown, MD Kings Mem 22. NAME AND ADDRESS OF FACILITY Baltimore, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE WM.C.March FH 1101 E. North Avenue 23. PART I. Enter the diseeses, or complications that coused the death not enter the mode of dying, such as cardiec or respiratory screet, shock, or heart fellure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Finel Onset and Death disesse or condition DEMENTIA ORTICAL 2 YRS resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF) If sny, lesding to immediate cause. Enter UNDERLYING CAUSE (Disease Dr Injury DUE TO (OR AS A CONSEQUENCE OF): that initisted eventa resulting in deeth) LAST PART ii. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PROTEIN ENERGY MALNUTRITION AVAILABLE PRIOR TO COMPLETION DF CAUSE 1 TYES 2 NO OF DEATH? IMMOBILITY SYNDROME 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA Nursing Home 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation М 1 YES 2 NO ВY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED 8 Could not be 4 Homicide COMPL CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. (Check only one) MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated, 296. SIGNATURE AND TITLE OF CERTIFIED BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) D51697 FEBRUARY 18, 1999 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SANJAY SETHI, UNION MEMORIAL HOSPITAL BALTIMORE MD 21218 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 1999

DHMH-18 Rev 1/89

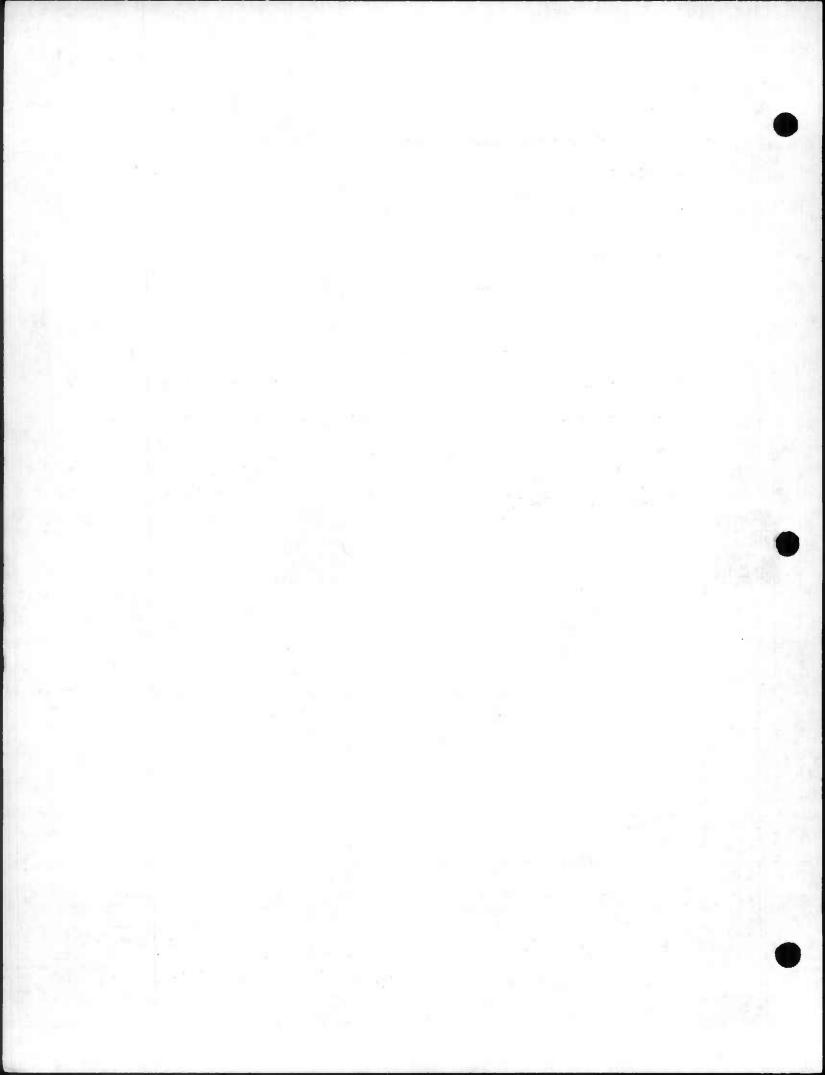


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State of Maryland / Department of Health and Mental Hygiene 9 9 0 5 0 7 4

hysicia: /Medica		1. Decedent's Neme (First, Middle, La	· .	8 7				2. Data of De	Reg. No. eath Day	14	Time of Death							
INCUICE	ı .	1110119	Chance					02	18	99 3	.45 pm							
xamine	r	ta. Facility Name (If not institution, giv Lorien Frankf			omo		4b. City, Town, or L Balto	ocation of Deat										
neral		5. Sociel Security Number 6. S	Sex 7. A	ge (In yrs. lest	birthday) If Und	ar 1 Year s Days	If Under 24 Hrs. Hours Min.	8. Data of Bir	th Year)	9. Birthplece	(State or Foreign							
ector	-	215-30-1019 Usual Residence of Decedent	I ZIMI ZIALI		Yrs.			June	1, 191	8 1	A							
notified at		Md 10b. County N/A		10c. City, To	own or Location Bal	to					nside City Limits Yes 2 No							
r items 23e or 28s-f single of the confront from		10e. Street and Number 437 E. 22nd St			10f. 2	212	1.0		10g. Citizen of V									
Linual	erai	11. Marital Status	12. Was Decadent Armed Forces	Evar in U,S.	13. Was Dec			ecify Yas or No		S . A . e - Amaricen Ir	ndian,							
Health and Mentale Hygiene. The marked other than "returel", or items 236 or 28s-f show other treumstice event, the Medical Evantiner mant be notified at To Be Completed by Funeral Director	Dy rur	1 Nevar Married 2 Married	Armed Forces' 1 Yas 2 If Yes, Giva Year or Datas:	(go	 13. Was Decadant of Hispanic Orlgin? (Specify If Yes, specify Cuban, Maxican, Puerto Ric 1 ☐ Yas 2 ☐ XNo Spacify: 			Ricen, etc.)		ck, White, etc. v: Black	hite, etc.							
	ered	15. Decedent's E (Specify only highast gra	ducation ide completed)	16	Se. Decedent's Us (Give kind of	ual Occup vork done	etion during most of work d)	ing	16b. Kind of B	usiness/Industr	у							
	dimo.	Etementary/Secondary (0-12) 1 2 t h	College (1-4or N/A	5+)	COOK					atering Co								
	0	17. Father's Name (First, Middla, Last, George Elam		1				18. Mother's Name (First, Middle, Meiden Sumeme) Ethel Matthews										
		19a. Informant's Name/Relationship (Margaret Black		1	-				i Route Number, City or Town, Stete, Zip Code)									
2		20a. Method of Disposition		20b. Place	of Disposition (A	eme of	St Balt	Data Data	ZIZI8	City or Town,	State							
		1 Burlel 2 Cremation 3 4 Donation 5 Other (Specif		Garr	ison Fo	res	VA Cen	26-9	Owing	TO MT1	le Md							
Important: If ite any injury or ot once.	87	20a. Method of Disposition 1								HOme Md 21	213							
		23a. Part1. Enter the disease, or comes shock, or heart failure. List only	plications that ceuse	d the death. D	o not antar tha m	oda of dyir	ng, such as cerdiac	or raspiratory a	rrest,	App	oroximate rvat Between							
	Medical Examiner	nedical Examiner	redical Examiner	Medical Examiner	redical Examiner	Medical Examiner	redical Examiner	Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	b	Due to (or es	a consequence of perfect e consequence o	n: -S1'02	r Acci	clent-			
9									De l	ם פריי	that initiated events resulting in death) Last	Due to (or as	a consequence of):				
d for	5	Pert II. Other significant conditions o	contributing to death but not resulting in the underlying ceuse given in Part I.					23b. Did	tobacco use co	ntributa to the	cause of death?							
by the attendireteched for use		De						10	Yes 2□ No	3 Probably	4⊟ Unknown							
Dhye				nentia				-	24a. Was an autopsy performed? 24b. Wera autops available principalities of complation complation.		utopsy findings le prior to							
Property of the physical physi	2 222	A	nemia					24a. Was perfo	an autopsy rmed?	compla	tion of ceuse							
page z should be deteche	a possibility	A	nemis					24a. Was perfo	rmed?	compla of death	tion of ceuse							
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il director, page 2 should	2	25. Was cese referred to medicet exeminer? 1 ☐ Yes 2☐ No	Hospital: 1 ☐ Inpatie	ant 2□ER/0	•		er: 44 Nursing Ho	perfo	Yes 2 No	compla of death 1 Ya	tion of ceuse 1?							
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pletely filled in by the funeral director, page 2 should be defined for the formulated by	2	25. Was cese referred to medicat exeminer? 1	Hospital: 28a. Dete of tripic (Month, Detection) 28e. Place of tripic in building, etc. 29 yelclan: To the best trinar: On the basis of end manner st	ant 2 ER/iny y Year) 28b y Yea	o. Time of Injury M ferm, street, factor ge, death occurre and/or investigation 2	28c. Injur Wor 1 - ory, office d at the tim n, In my o	er: 4 Nursing Ho	performe 5 Residue Res	Yes 2 No None) dance 6 Oth how Injury occur Street end Numb cause(s) end ma dete and ptace, a 29d. Date signer	er (Specify) red er or Rural Roo anner es stated end due to the d (Month, Dey,	tion of ceuse 1? s 2 No ute Number, cause(s)							

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ITFM: #5 PER F.H. G769 3-19-99 WR. Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Dey Month Year Paul Vincent Cincinnati February 18, 1999 7:15 AM 4e Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death 1119 Gallatin Way Pasadena Anne Arundel 5. Social Security Number 7. Age (In yrs. lest birthday) if Under 1 Year 6. Sex 1 M 2 ☐ F If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dev. Year) Months Deys Hours 69 Yrs. 172-28-0778 October 24, 1929 Pennsylvani Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Anne Arundel Pasadena 10e. Street end Number 10f. Zio Code 10g. Citizen of Whet Country? 1119 Gallatin Way 21122 USA 14. Race - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Stetus 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Yeer or Dates: 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Barber Self-Employed 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) Vincent P. Cincinnati Mollie Fee 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informent's Name/Reletionship (Type, Print) Carmella M. Cincinnati-Wife 1119 Gallatin Way, Pasadena, MD 21122 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 X Burlei 2 ☐ Cremation 3 ☐ Removel from State Gate of Heaven Cemetery Feb.20 | Silver Spring, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Pert1. Enter the disease, or complications that caused the data? Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death immediate Ceuse (Finel NOW- SMALL CELL LING CANCER MOTASOATIC disease or condition resulting in deeth) Due to (or es e conseguenca of): to LIVER + RIGHT SCAPULA Due to (or es e consequence of): Due to (or es e consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

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Director

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Completed

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Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mentel Hygiene.
Important: If Item 27 is marked other than "natural", or iten any injury or other treumentic event, the Medical Evantine page.

altimore, Maryland 21215-0020

P.O. Box 68760.

Records,

Division of Vital

The law requires that the death certificeta signed by the a

death with the Marylend

Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in deeth) Lest Physician/Medicai à

Completed

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10

Certification:

edical

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evellable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Aesidenca 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stated. 29a. Certifier

To the Hospital or Atterview within 24 hours after deserto To the Funeral Directo completely filled in by the

s certificate hes director, page 2

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director,

Kulin To Ms

29c. License number D21336

29d. Date signed (Month, Dey, Year) 2/18/99

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

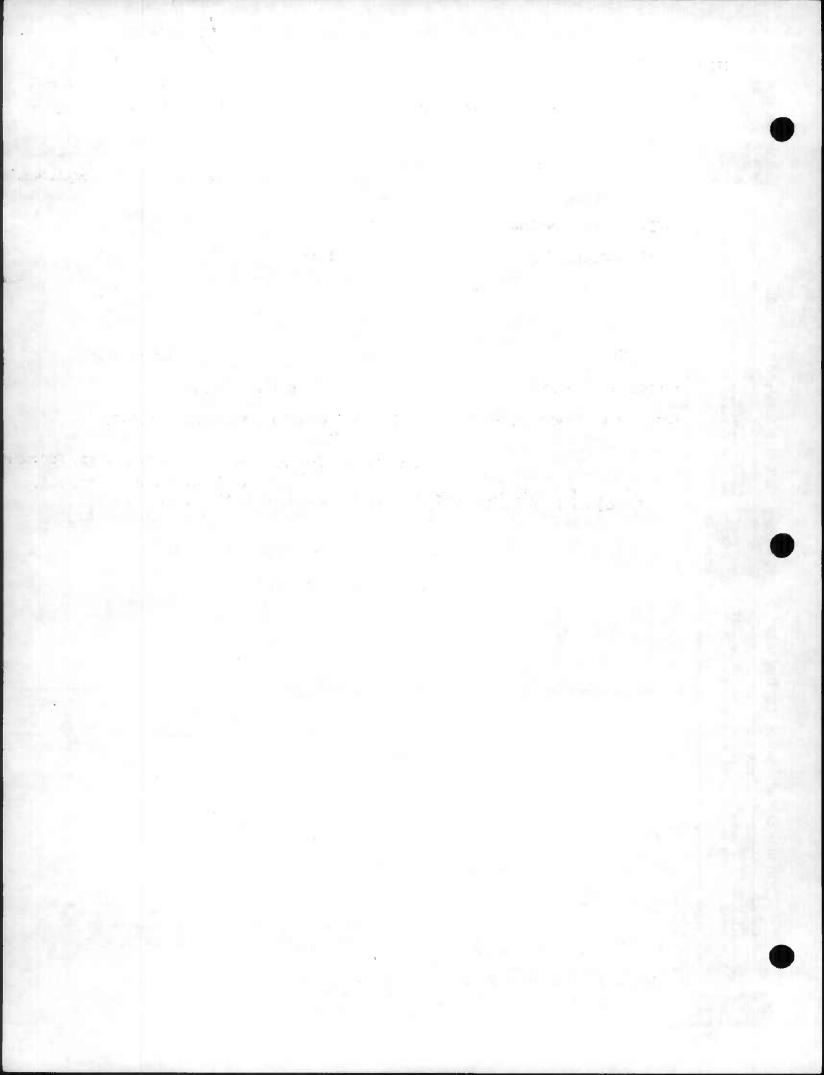
ALSIN KUHNIL, M. D BOZB FITCHIE HIGHWAY, PASADEWA, MAKYLIND 21122

31. Dete filed (Month, Day, Year) FEB 2 2 State Registrar

29b. Signeture end title of certifier

32. Registrer's Signeture

sach)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month 9130AM HATTIE E. COLE 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death CHURCH HOME HOSPITAL BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 6. Sex 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (Steta or Foreign Country) Days 1□M 2□F 245-38-2183 73 APRIL 18, 1925 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits X1 ☐ Yes 2 ☐ No MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1042 N. MILTON AVE. 21205 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, GiveX Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. 1 □ Never Merried 2 □ Merried 1 Yes 2 No Specify: Specify AFRO-AMERICAN 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A LAUNDRY AIDE NURSING HOME 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) REV. PINK HENRY PASSON VINNIE SULLIVAN 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TRYPHENA EDGE / DAUGHTER 1119 N. MILTON AVENUE BALTO, MD. GEORGE COLE / SON 20e. Method of Disposition 20b. Pleca of Disposition (Name of ER AVENUE BALTO, M. 20c. Location City or Town, Stete cemetery, cremetory or other place) 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) GARRISON FOREST VET. CEM. 2/25/99 BALTO. CO, MD. 22. Name end Address of Fecility CALVIN B. SCRUGGS FUNERAL HOME 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. 1412 E. PRESTON ST. BALTO, MD. Approximete Intervel Between Onset end Death 2 wko Cardiac arrhythmias Immediate Ceuse (Finel disease or condition resulting in deeth) Due to (or as a consequence of): 2 wks Myocardial Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) thet initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Premaria 1 Yes 2 No 3 Probably 4 DUnknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes an eutopsy performed?

Physician /Medical Examiner

Physician

/Medical

Examiner

10e. Stete

Director

Be

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Illed to Il Hygie

52 should be fi h and Mental H 7 is marked off

Pages ment of t

Baltimore, Maryland

Physician/Medical Examiner þ

Be Completed

Box (P.O. Records, of Vital this Division or Attending After after death.

Director: Aft
d in by the fur

To the Hospital of within 24 hours af To the Funeral Dicompletely filled in State

Medical

To 27. Menner of Deeth Certification:

25. Wes case referred to medical 1 Yes 2 No

11 Netural

2 Accident 3 Suicide

4 | Homicide

(Check only one)

29b. Signature and title of certifier

29e. Certifier

5 Pending investigetion

6 Could not be

Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year)

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Tyes 2 □ No

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end piece, and due to the cause(s) end menner steted.

BLVD,

26. Place of Deeth (Check only one)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

1 Yes 2 No

28d. Describe how injury occurred

29c. License number 113605 29d. Date signed (Month, Dey, Year) 02-18-99

BALTIMORE, MD-21221

1 ☐ Yes 2 ☐ No

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

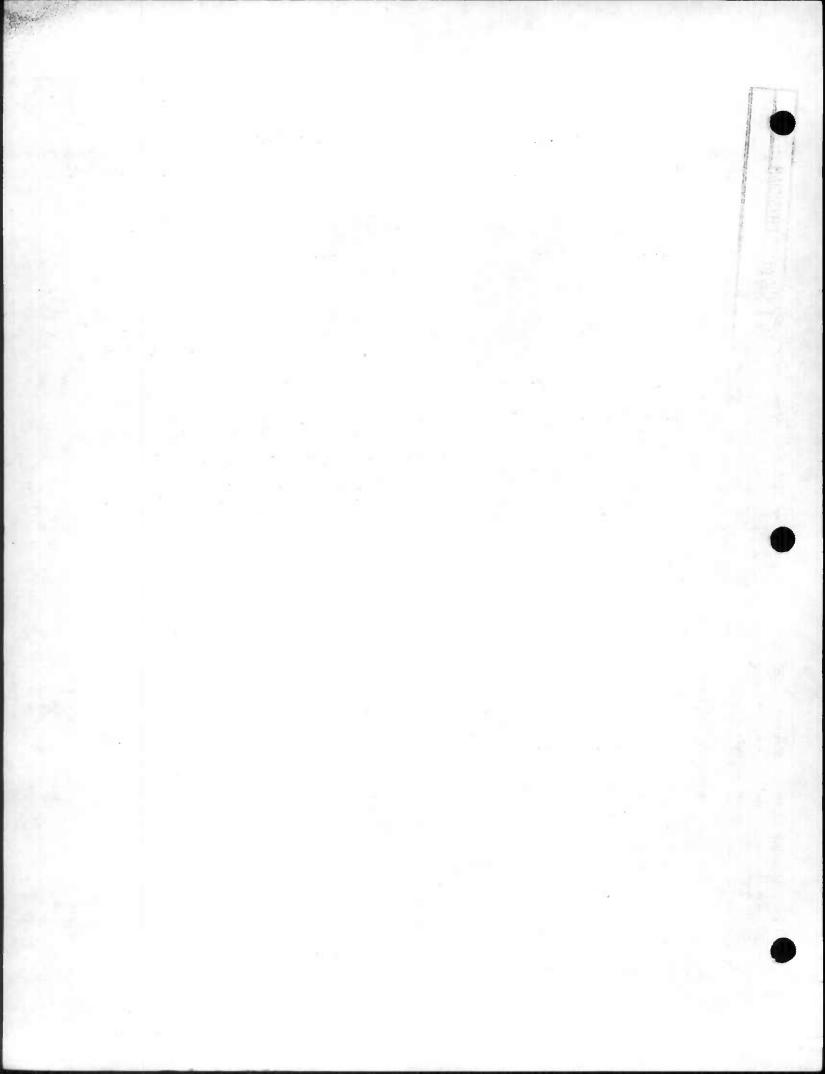
WASBEM. 404. BASTERN 31. Dete filed (Month, Dey, Year)

Mason

FEB 22

32. Registrar's Signeture 1999

Registrar **DHMH 16 Rev 6/95**



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middla, Last) Month MICHAEL **Physician** 358AM 115715 999 FEBRUARY /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY BALTIMONE JOHNS HOPKINS HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Min. (Month, Day, Year) MAY 3, 19 5. Social Security Number 9. Birthplace (Stata or Foraign 7. Age (In yrs. last birthday) **Funeral** 1□M 2□F 44 Yrs. MARYLAND Director 218-60-4477 Usual Residence of Decedent with the Meryland 10a State 10b. Count 10c. City. Town or Location 10d. inside City Limits ail, or items 23s or 28s-f show Examiner must be notified at MARYLAND BALTIMORE 1 Yes 2 No N/A Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1712 E. LANVALE STREET 21213 U.S.A. death y Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status ommit. Pages 1 and 2 should be filed within 72 hours after a Department of Realth and Mentel Hygiene. In few 27 is marked other than "natural", or item 1 Tyes 2 No
If Yes, Give Vear or Dates: 1 ☐ Never Married 2 Married SpeciAFRO-AMERICAN 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced 6-21-74 Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) PATUXENT CORRECTIONAL 12TH N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumama) DELORES MACKEL JAMES CUSTIS 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1712 E. LANVALE STREET BALTIMORE, MD. DELORES CUSTIS DUTTON 20b. Place of Disposition (Nama of cematery, cramatory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Garrisonitorest Com. 73 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1412 E. PRESTON ST. BALTO, MD. Approximate interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical MULTIPLE OPLEAN SYSTEM FAILURE Examiner Physician/Medical Examiner SEPSIS Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) pue ENDOCANDITIS FOUR MONTHS Division of Vital Records, P.O. Box 68760, ettending physician for use es the buria 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? should t 24a. Was an autopsy parformed? Completed hes 92 page 2 No certificate or Attending Physician: 25. Was case referred to medicel examiner? Be 26. Place of Death (Check only ona) 1 ☐ Yes No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Naturai 5 Pending Investigation 24 hours efter deeth.

• Funeral Director: Aft
bletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 281. Location (Streat and Number or Rural Routa Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) 4 Homicide 29a. Certifie 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only one) Within 2 29b. Signature and little of certifie 29c. License number 29d. Date signed (Month, Day, Year) PHYSICIAN JHU-04585 FEBRUARY

JOHNS HOPKINS HOSPITAL, BALTIMORE,

Registrar

30. Name and address of parson who completed ceuse of death (Item 23a) (Type, Print)

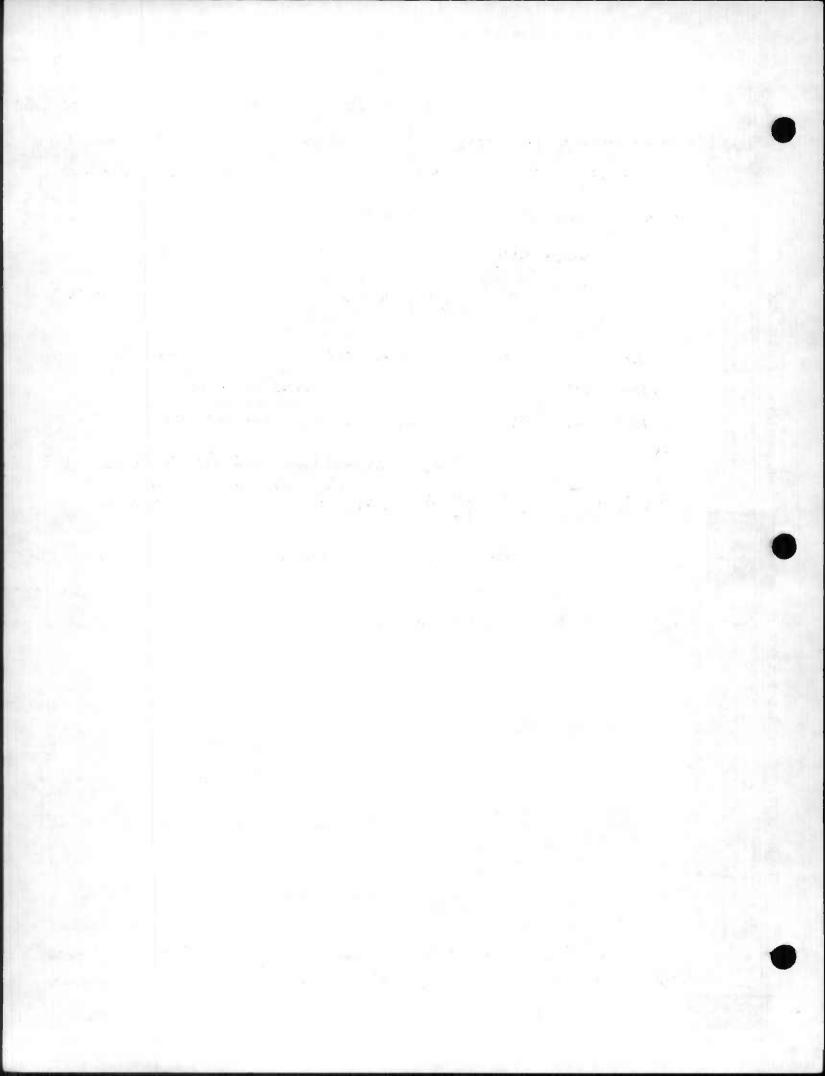
FEB 2 2 1999

MS.

32. Registrar's Signature

DANIEL MOST,

31. Date filed (Month, Day, Yaar)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Daath 3. Tima of Death Month 4a. Fecility Nama (If not institution, give street end number) CLEMMONS FEBRUARY 15, 1999 11:10 PM 4b. City, Town, or Location of Death 3700 GWYNN ial Security Number 6. Sex BALTIMORE If Under 24 Hrs. 8. Data of Birth FALLS HARKWAY 7. Aga (In vrs. lest birthday) If Undar Yaar 5. Social Security Number 8. Data of Birth (Month, Day, Birthplaca (Stete or Foreign Country) 1 M 2 KF Months Days MARYLAND Usual Rasidance of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 □ No BALTIMORE CI MARYLAND 10g/Citizan of What Country? 10a. Street end Numbar 3700 GWYNN FALLS HARKWAY USA. 12. Was Dacedant Evar In U,S. Armed Forcas? 1 Yas 2 No If Yas, Giva Yaar or Datas: Raca - Amarican Indian, Bleck, Whita, atc. 11. Marital Status 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 1 Navar Married 2 Married 1 ☐ Yas 2 No Specify: Specify: BLACK 3 Widowad 4 Divorcad 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Dacadant's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elemantary/Sacondary (0-12) SHGRADE Collaga (1-4or 5+) SUPERVISOR CATHOLIC SISTERS OF HERCY 17. Fathar's Nama (First, Middle, Lest) 18. Mothar's Nama (First, Middle, Maiden Surneme) WILLIAM DOYER VIOLET 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) CLYDE CLEMMONS (HUSBAND) AND) 2/29 N. FULTON AVE., 20b. Placa of Disposition (Name of cametery, cremetory or other place) BALTO. MD. 21217 20a. Mathod of Disposition 1 X Burial 2 □ Cramation 3 □ Ramoval from Stata GARRISON FOREST 4 ☐ Donation 5 ☐ Othar (Specify) 02-23-99 OWINGS MILLS, MD. 21. Signature of Funaral Sarvice Licensea CLOSEDING TO BROWN JR FINERAL HOME 2140 N. FULTON AVE., BALTIMORE, NO ot antar the mode of dying, such es cardiac or respiratory arrest, Approximate 2/207 interval Batween Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediata Causa (Final L24 pres disaasa or condition rasulting in daath) Sequantielly list conditions, if eny, leading to Immadiata causa. Enter Underlying Causa (Disaase or Injury thet initieted events resulting in death) Lest Dua to (or as a consaquance of) Part II. Other stgniflcant conditions contributing to death but not resulting In the underlying cause given in Part I. 23b. Did tobacco usa contribute to the causa of death? 3 Probabty 4 Unknown RUDERTENTION, 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? 1 ☐ Yas 2 ☐ No 26. Plece of Death (Check only one) Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

the Medical Examiner must be notified

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items 23a

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permit. Peges 1 and 2 should be 1 Depertment of Health and Mantal I Important: If item 27 is marked of any injury or other traumatic eve

Hygiene.

Baltimore, Maryland

68760

Box

P.O.

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Division

Director

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Completed

physic signed t page

Physician/Medical Examiner à Completed Be 10 Certification:

After or Attending death. To the Hospital or Attendi within 24 hours efter death To the Funeral Director: A completely filled in by the f

25. Was case rafarred to medical examinar? 1 Yas 2 No 27. Manner of Death 1 Daturel 2 Accidant 3 Suicida

4 Homlcide

(Check only one)

5 Pending invastigation

6 Could not be determined

28a. Data of Injury (Month, Day Year)

Could not be determined

28e. Placa of Injury - At home, farm, straat, factory, offica

28f. Location (Street end Number or Rurel Route Number of Rurel Ro

28b. Tima of

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

28d. Describe how Injury occurred

29b. Signature end titla of certifiar SANTRA E BROOKS, NO 29c. Licansa numbar

29d. Data signad (Month, Dey, Year)

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32. Ragistrar's Signetura

Registrar

Medical

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State Registrar

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HTWAR M.D. LEVINDALE 2434 WEST BELVERDERE AVENUE BALTIMORE MI)

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ATTENDING

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

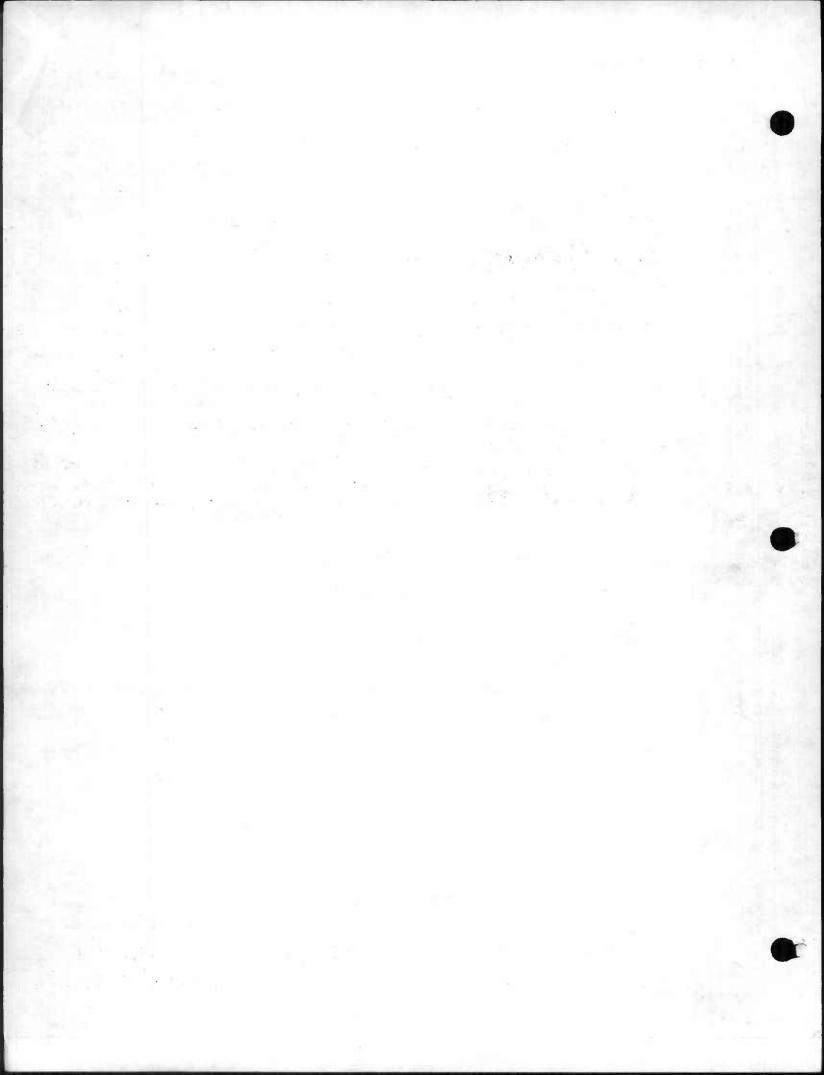
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32. Registrar's Signeture

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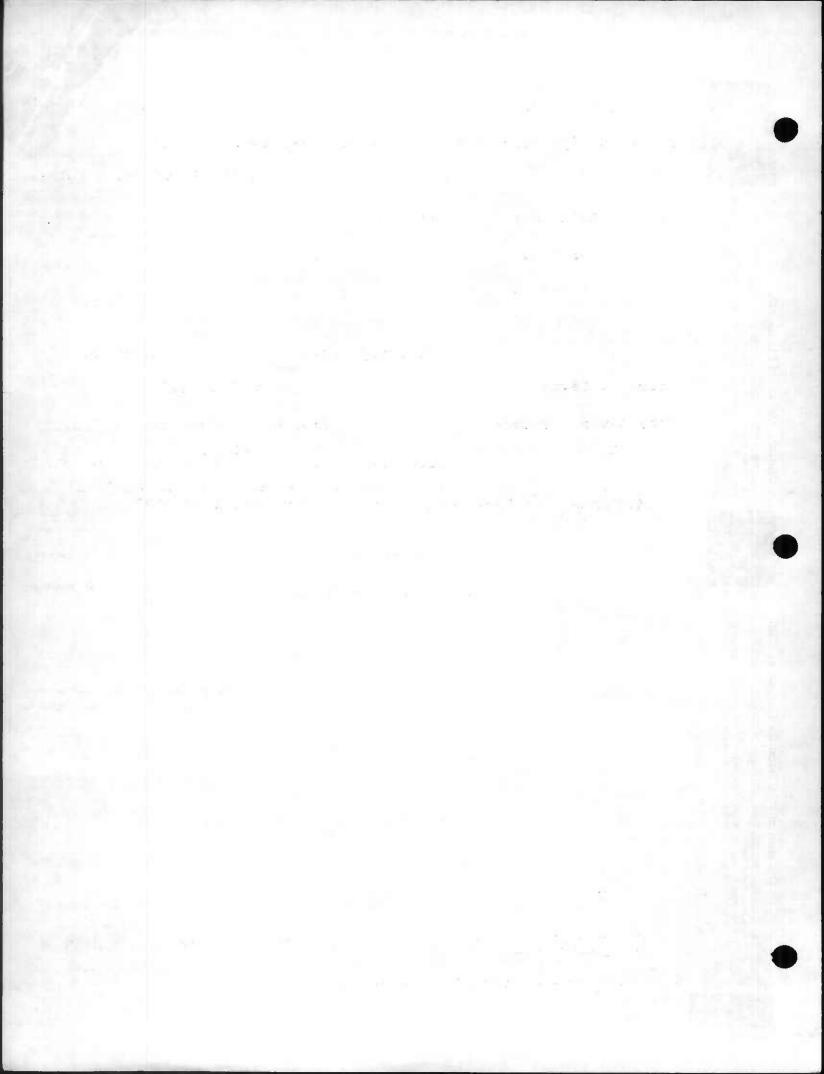
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31. Date filed (Month, Day, Year)



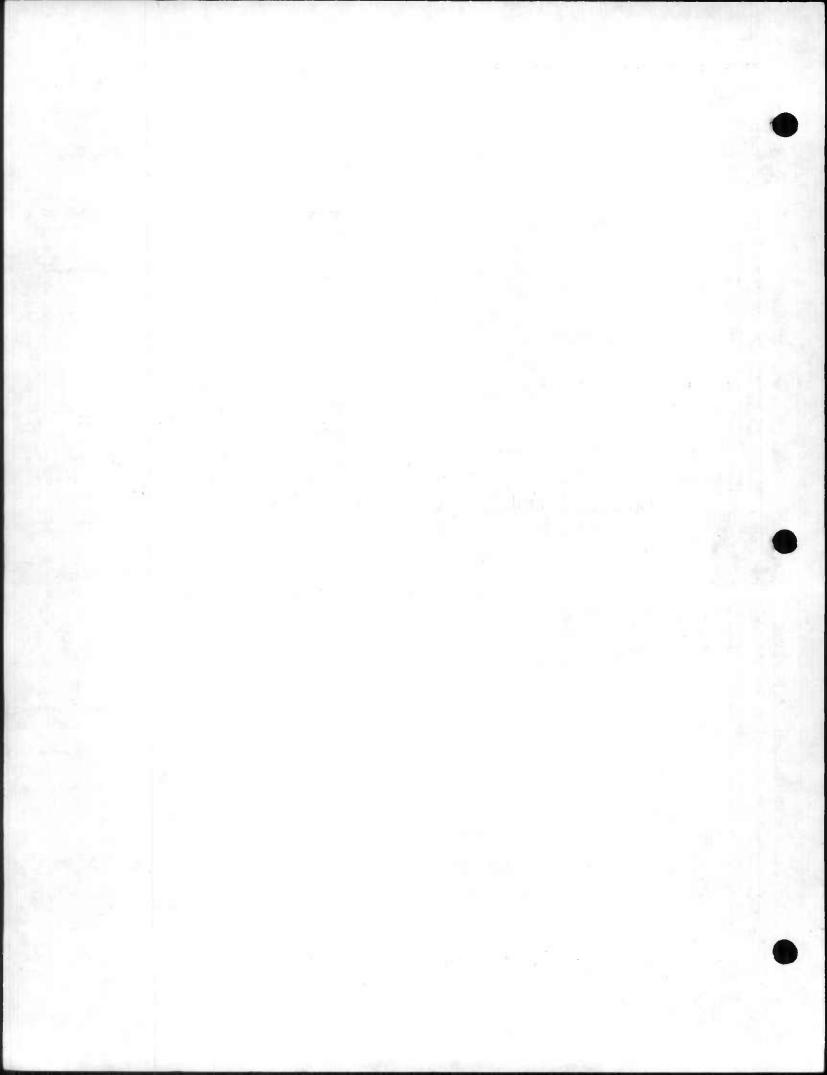
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Baltimore,	S to L		20a. Method of Disposition 1 ☐ Buriel 2 🕅 Cremetion	☐Removal from State	COL	netery, crem	e of Disposition (Name of etery, cremetory or other place) Feb 22					20c. Location - City or Town, State		WII, State	
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S: #10C, 19	9B, PER F.H. G769	State of Maryl 3-1-99 WR.		artment of rtificate o		Mental Hy	giene	05001	
1. Deci	edent's Name (First, Middle, L	ast)				2. Dete of De	eth	3:-Time of Death	
sician edical	Harold	W	Edu	ards		Februa	Day 19 1	Year 999 1538	
	cility Name (If not institution, g	rive street and number)			4b. City, Town, o	Location of Deet			
Un	liversity of n	nanyland Med	dical Sy	stem	Baltimo			N/A	
	The state of the s	Sex 7. Age (In)	yrs. last birthday)	If Under 1 Yes		1. (Month, De	th by, Year)	Birthplace (State or Forei Country)	
	2-07-6724		81 Yrs.			Decembe	er 3,191	7 Maryland	
Oa. St	Residence of Decedent tate 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limi	
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	ryland Anne A	runder	Tus	10f. Zip Code			10g. Citizen of V	/hat Country?	
140		d		2114				USA	
	08 Larch Roa	12. Was Decedent Ever is	n U.S. 13. \			Specify Yes or No	- 14. Raci	- American Indian,	
10	Never Married 2 (2) Merried Widowed 4 Divorced			f Yes, specify Ci	f Hispanic Origin? (uban, Mexican, Pue lo Specify:	rto Rican, etc.)		k, White, etc. . White	
	15. Decedent's I		16a. Deced	lent's Usual Occ	supation		16b. Kind of Bu	siness/Industry	
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17. Fat	ther's Neme (First, Middle, Las	st)			18. Mother's Na	ame (First, Middle	, Maiden Surnam	θ)	
Geo	orge Edwar	ds			Anna	r Fra	ink		
19a. In	nformant's Neme/Relationship	(Type, Print)	19b. Mailir	ng Address (Stre	et and Number or F	Rural Floute Numb	er, City or Town,	Stete, Zip Code)	
Fra	ances E. Edwar			1408 La	rch Road,	Pasader	ia, MD 2	21144	
	lethod of Disposition A Burial 2 Cremetion 3		 b. Place of Dispo cemetery, cren 	sition (Name of natory or other p	elece)	Dete	20c. Location -	City or Town, Stete	
	☐ Donation 5 ☐ Other (Spec		Glen Hav	en Ceme	terv	Feb 23	Glen Bu	urnie, MD	
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Sequentially list conditions, Due to (or as e consequende of): if any, leading to immediate Cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of):									
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								completion of cause of death?	
						10	Yes 20 No	1 ☐ Yes 2 ☐ No	
25. Wa	as case referred to medical				26. Place of D	eath (Check only	one)		
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	nner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c. In	jury et vork?	28d. Describe	28d. Describe how injury occurred		
2	Accident investigation			M 1	☐Yes 2☐No				
	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, fectory, office 28f. Location (Street and N City or Town, Stete)						er or Rural Route Number,	
		hysician: To the best of my miner: On the basis of examiner and manner stated.	knowledge, death ination and/or inv	occurred et the restigation, in m	time, date and place y opinion, death occ	ce, and due to the curred at the time,	cause(s) and ma date and place, o	nner as stated. and due to the cause(s)	
29b. Si	ignature and title of certifier			29c. Lice	nse number		29d. Date signed	(Month, Day, Year)	
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene O

Certificate of Death

2. Data of Death

3. Time of Death

12:34 pm

Birthplaca (Stata or Foraign Country)

White

Approximata Interval Batween Onset and Death

MINUTES

2 DAYS

24b. Wara autopsy findings available prior to

complation of ceusa of death?

1 ☐ Yes 2 ☐ No

10d. Insida City Limits

1X Yas 2 No

Physician /Medical Examiner 1. Decedent's Name (First, Middla, Last)

Funeral Director

with the Maryland r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at permit. Pagas 1 and 2 should be filed within 72 hours after death v. Department of Health and Mentel Hygiena. Important: If item 27 is merked other than "natural", or items 23a and injury or other traumatic event, the Medical Examiner mast once.

> **Physician** /Medical Examiner

physician end the buriel-transit The law requires that the deeth certificete be executed ed by tha detached bengis be det Division of Vital Records, s cartificate hes t director, pega 2 s diractor, or Attending Physician: this funarel daath. after daath Director: A within 24 hours aft To the Funeral Dir complately filled in

17, 1999 Frances Madeline Erdman February 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death 2108 Boston St. "Apt 602" Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) 1□M 2XF March 11, 1916 Maryland 215 05 1804 Yrs. Usuel Rasidance of Decedant 10a. State 10b. County 10c. City, Town or Location N/A Baltimore Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2108 Boston St. "Apt 602" 21231 USA Funeral 12. Was Decedant Ever in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 14. Race - American Indian, Black, Whita, atc. 1 ☐ Yes 2 XNo If Yas, Giva Year or Datas: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 X No Specify: Specify. þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decadant's Education (Specify only highast grade complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Seamstress Hospital 12 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Martin Zoran Anna Soltysiak 19a. Informent's Nama/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rurel Route Numbar, City or Town, Stete, Zip Code) Stephen Erdman (Son) 11833a Falls Rd. Cockeysville, Md. 21030 20b. Place of Disposition (Nama of camatery, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1X Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Stanislaus Cemetery 2/20/1999 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. 21. Signatura of Funaral Sarvice Licensas 22. Nama and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221 Parl. Enter the disease, or complications that cars of the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Immediata Causa (Final disaasa or condition rasulting In daath) 18 RMINAL CARDIAC ANNHYTHMIA Dua to (or as a consequence of): Examiner 1 SCHEMIA MYOCARDIAL Sequentially list conditions, if eny, laeding to immadiate causa. Enter Underlying Causa (Disaase or Injury that initieted events rasulting in death) Last CORONANT ANTERT INSUFFICIENCY

Due to (or as a consequence of): Physician/Medicai a ATHEROSCLEROTIC CARDIOURSCULAR DISEASE 12 YEARS Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION þ OF SPINE 24a. Was an autopsy performed? Completed OSTED ANTHAITIS 1 ☐ Yes 2 No Be 25. Wes cesa rafarred to medical exeminar? 26. Place of Daath (Check only ona) Hospitel: Othar: 4 ☐ Nursing Home 5 🖾 Rasidence 6 ☐ Other (Specify) 2 1 Yes 20 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

Medical

Certification:

31. Date filed (Month, Day, Yaar) FEB 2 2 1999

27. Menner of Death

1 XNatural

2 Accident

3 Sulcida

29a. Certifiar

4 Homicida

29b. Signature and title of certifier

5 Pending invastigation

6 Could not be

32. Ragistrar's Signatura

28a. Data of Injury (Month, Day Yaar)

30. Name and eddress of person who completed cause of daeth (Nem 23a) (Type, Print)

28b. Time of

28a. Place of Injury - At homa, farm, straet, factory, office building, atc. (Spacify)

28c. Injury et Work?

1 Certifying Physician: To the best of my knowledge, daath occurred at tha tima, date and place, and dua to tha causa(s) and mannar es steted.

2 Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, dete and place, end due to the cause(s) and mannar statad.

29c. Licansa number

1 ☐ Yas 2 ☐ No

JOSEPH D. NOTARANGELOM.D. 301 ST. PAUL PLACE BALTIMONE MOZIZOZ

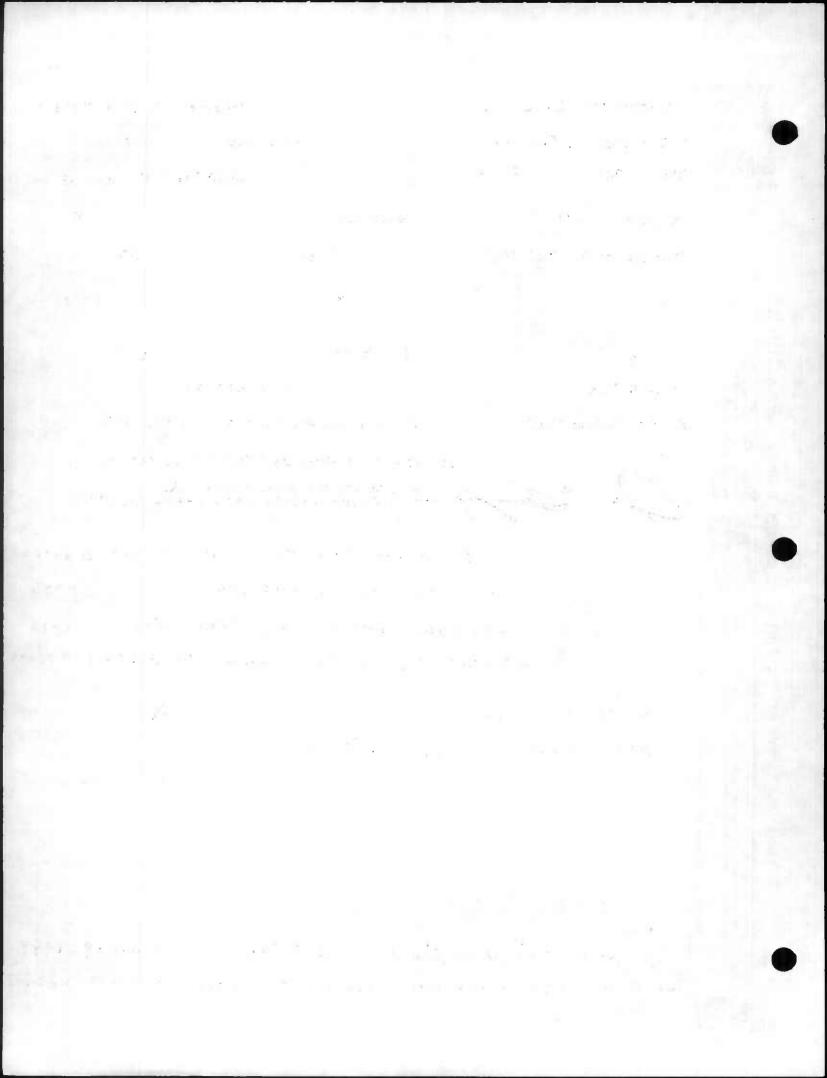
28d. Describe how injury occurred

28f. Location (Streat end Number or Rural Routa Number, City or Town, Stata)

29d. Date signed (Month, Day, Year) FEBRUARY 19-1999

Registrar

To the



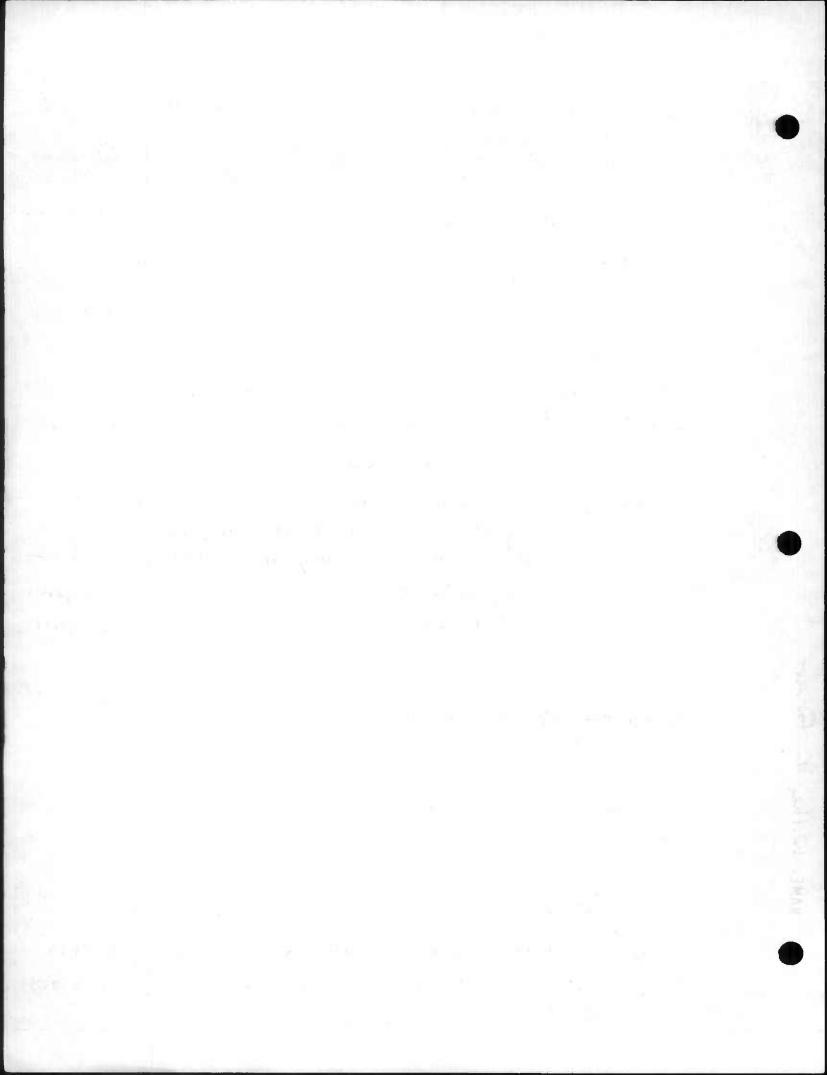
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** +ARMER FEBRUARY 1999 EWIS 0931 AM /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death **Examiner** BALTIMORE
If Under 1 Year If Under 24 Hrs. 8.1 AGNES HOSPITAL NA PAINT 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Days Hours 211- 20- 3250 Usual Residence of Decedent 10 Yrs. NC Director 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits 7 is marked other than "natural", or items 23e or 28s-f show traumatic event, the Medical Examiner must be notified at 1 PYes 2 □ No Director BALTIMORE MD NIA 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? BRAESIDE 21229 826 MOAD USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer to Depertment of Health and Mentel Hygiene. Important: if Item 27 is merked other than "natural", or iter any injury or other traumatic event, the Medical Exemi 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 € No Specify: þ BLACK 3 ☐ Widowed 4 ☐ Divorcad Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NIA SHOREMAN 7 TH GRADE DOCK S 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be EWIS +ARMER BEATRICE WILLIAMS 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) TARMER INNIE WIFE BRAESIDE BALTIMORE MD. 21229 20b. Placa of Disposition (Name of cametery, cremetory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2-23-99 BALTIMORE, 4 ☐ Donetion 5 ☐ Other (Specify) CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility VAUGHN C. GREENE FUNERAL SERVICE In, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest,

List only one cause on each line.

Syddu Curdus of dying, such es cardiac or respiratory arrest, 23a. Part1. Enter the discharge shock, or heert fallum Approximate Interval Between seconder Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) COMMO Examiner Due to (or as a consequence of) Examiner MSUN attending physician end for use es the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequenca of): Records, P.O. Box 68760. 'ushe Les Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to Completed 24e. Wes an autopsy completion of cause of deeth? After this certificate has 2 1 No 1 Yes 1 ☐ Yes 2 ☐ No **Division of Vital** Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 Yes 2 No 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Hatural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital of within 24 hours a To the Funarel Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) end manner as stated.
2 Median Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical ner: On the basis of examinetion and/or Investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and manner stated. 29b. Signature end title of certifie 29c. License number 29d. Date signed (Month, Day, Yeer) Cebruay 18, 1999 D50708 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue Bultimore and South Can 200 31. Date filed (Month, Day, Year) 32. Registrer's Signature State FEB 2 2 1999 Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® (Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** FRANCIS FEBRUARY 19, 1999 FUGATE 3:30 A.M. RICHARD /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner 7504 KNOLLWOOD ROAD **TOWSON** BALTIMORE If Undar 1 Year if Undar 24 Hrs. 9. Birthplaca (Stata or Foreign 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 10XM 20 F Yrs. OKLAHOMA Director 442-18-2855 08/19/21 Usuel Residence of Dacedant with the Maryland 10a Stata 10b. County 10c. City. Town or Location 10d. inside City Limits r 28a-f ahow 1 ☐ Yes 2X No Director MD BALTIMORE TOWSON 10e Street and Number 10f. Zip Coda 10g. Citizan of What Country? r than "natural", or items 23s or the Medical Examiner must be a 7504 KNOLLWOOD ROAD 21286 death Funeral USA 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Orlgin? (Specify Yes or No-It Yas, specify Cuban, Maxicen, Puarto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, Whita, atc. Pages 1 and 2 should be filled within 72 hours after nant of Haaith and Mental Hygiena. nt: If item 27 is marked other than "natural", or ite 1 XYas 2 No if Yas, Giva WWII & Yaar or Datas KOREAN 1 Nevar Married 2 Marriad altimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: ۵ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 15. Decadant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry College (1-4or 5+) Elamantary/Secondery (0-12) RALEIGH BAPTIST CHURCH MINISTER 4 YEARS Is marked other traumatic event, it 18. Mothar's Nama (First, Middla, Meidan Sumeme) 17. Fathar's Name (First, Middla, Last) Be IRA MANNERS FUGATE EMMA ANGELINE BALLARD 19a. intormant's Name/Ralationship (Type, Print) 19b. Malling Address (Straat and Number or Rural Route Numbar, City or Town, Stata, Zip Code) item 2. BONNIE KLIMA DAUGHTER 7504 KNOLLWOOD ROAD TOWSON, MD 21286 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Important: If it any Injury or o 1X Buriai 2 ☐ Cramation 3 ☐ Ramoval from Stata permit. Page Department of 4 Donation 5 Other (Specify) MEMORIAL PARK CEMETERY 2/25/99 BARTLESVILLE, OKLAHOMA 21. Signature of Funaral Sarvice Licensea 22. Name and Address of Facility
THE JOHNSON FUNERAL HOME, P.A. N the 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a. Pant: Erter the disease, or complications that couled the death. Do not antar the mode of dying, such as cerdiac or respiratory arrast, shock, or heart tailure. List only one cause on each line. Approximata Intarval Batwaan Onsat and Daath **Physician** /Medical Immediata Causa (Final diseese or condition rasulting in death) 2 days Sepsis Examiner Dua to (or as a consequence ot) Examiner 3 weeks Socral Decubitus in faction ulcer attending physician and for use as the burial-transit the death certificate be executed Sequentially list conditions, if any, laading to immediata ceusa. Entar Undarfying Causa (Disaasa or Injury that initiated avants rasulting in death) Last Dua to (or as a consequence ot): 8 months Severe dementiq Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? ed by the a Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown requires that high blood signed t pressure Severe dementa, Records, b 24b. Were eutopsy tindings available prior to should I 24a. Was en autopsy performad? Completed complation of causa of death? aw. ls cartificata has I 1 Yas VENo 1 Yas 2 LNO or Attending Physician: 25. Was cesa retarrad to medicel axaminar? Be 26. Pleca of Daeth (Check only ona) Hospital: Other: 4 Nursing Home 51 Assidance 6 Other (Specify) 1 Yas 2 No 2 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Deta of Injury (Month, Dey Year) 28b. Tima of 28d. Dascribe how Injury occurred 27. Manner of Death 28c. Injury et Work? Certification: After 5 Panding invastigation 1 Natural of Funeral Director: Al Dietely filled in by the fu 1 ☐ Yas 2 ☐ No death. 2 Accidant 6 Could not be datarmined 3 ☐ Suicida 28a. Place of Injury · At homa, farm, straet, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner as steted. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi edical (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29b. Signatura and titla of certifiar 29c. License number 29d. Data signed (Month, Day, Year) D0052104 February 19, 1999 m.b 30. Nama and addrass of person who complated ceusa ot daath (Itam 23a) (Type, Print) Hopkins Bayuew Circle maryland Timothy Baltmare 100

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State

Registra

31. Data filad (Month, Day, Year)

32. Registrar's Signature

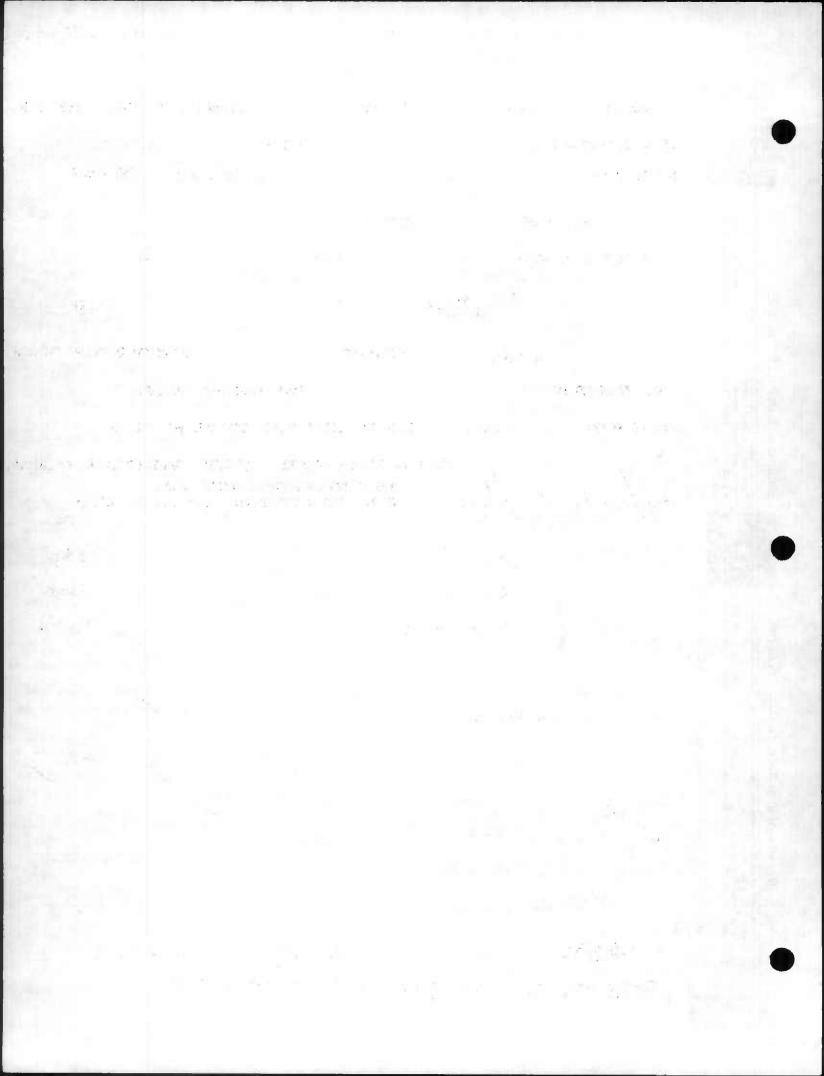
1999

FEB 22

Box 68760

P.O.

Division of Vital



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 1 1999 2:30 fim Sheppard Faulstich 4e Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death Glen Burnie // If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) North Arundel Hospital Anne Arundel If Under 1 Year Months Days 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland Hours 81 Yrs. August 15,1917 212-09-8133 Usuel Residence of Decedani 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13 C Warren Lodge Court 21030 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ ☐ No If Yes, Give Yeer or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Naver Merried 2 Married 1 Yes 2 No Specify: Specify: White 3 Ø Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Procurement Specialist Westinghouse 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Loretta Hughes Joseph Faulstich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Raletionship (Type, Print) Faulstich-daughter 13 C Warren Lodge Ct., Cockeysville, MD 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 D Burial 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Holy Redeemer Cemetery Feb 23 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, md 21122 23a. Pert1. Enter the disaase, or complications the caused that shock, or heert feilure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata interval Between Onset and Death Immediate Ceuse (Final disaase or condition rasulting in death) FORFATTATED LUNG CANCER for months Sequentially list conditions, if any, laading to immediate cause. Enter Undarlying Cause (Disaase or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2. No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At horna, farm, street, factory, office building, atc. (Specify)

Examiner Box 68760 Physician/Medical the P.O. signed by the Records, þ Completed Vital Be Medical Certification: To Division of

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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'natural', or

Important: If Item 27 is m any injury or other traum 2008.

Physician /Medical

Examiner

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altimore,

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Completed

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Depital or Attending Physician: hours after death, ineral Director: After this certifica To the Hospital or within 24 hours aft To the Funeral DI completely filled in

State Registrar

31. Dete filed (Month, Day, Year) FEB 2 2

4 Homicida

29e, Certifiar (Check only one)

29b. Signature and title of certifier

1999

MAD

29c. License number

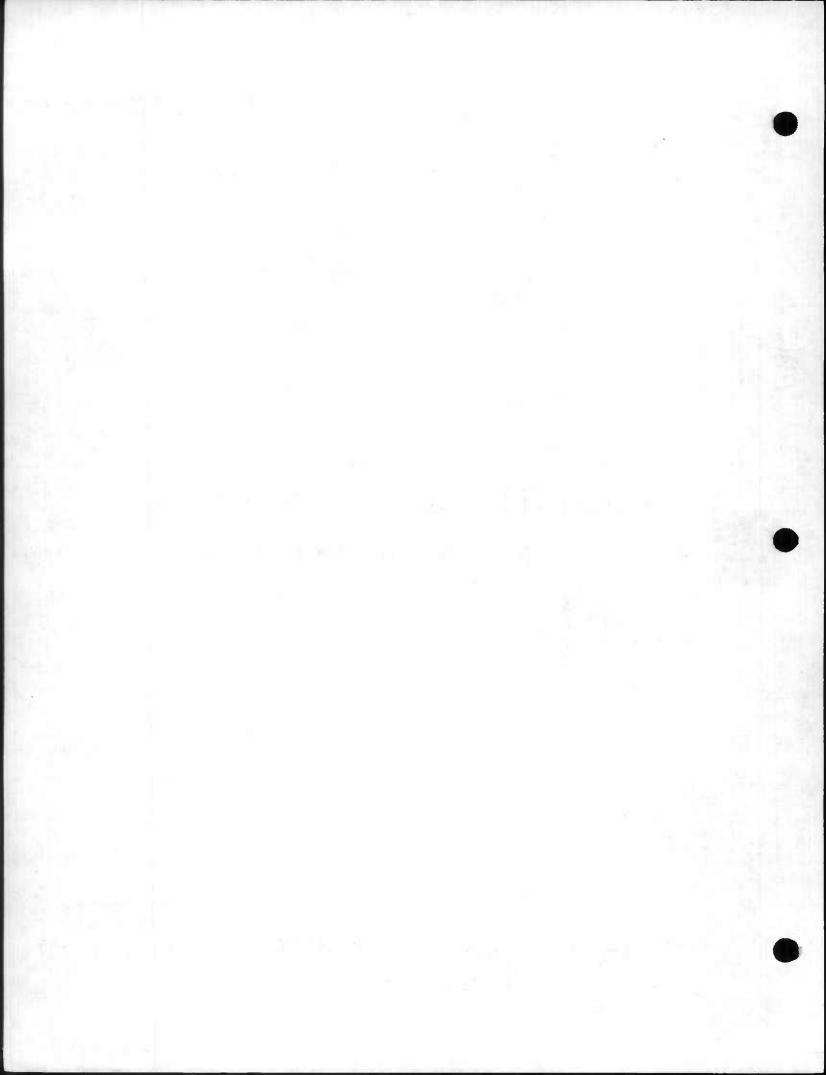
NZ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Dave 103672 105 acesun11

32. Registral's Signature

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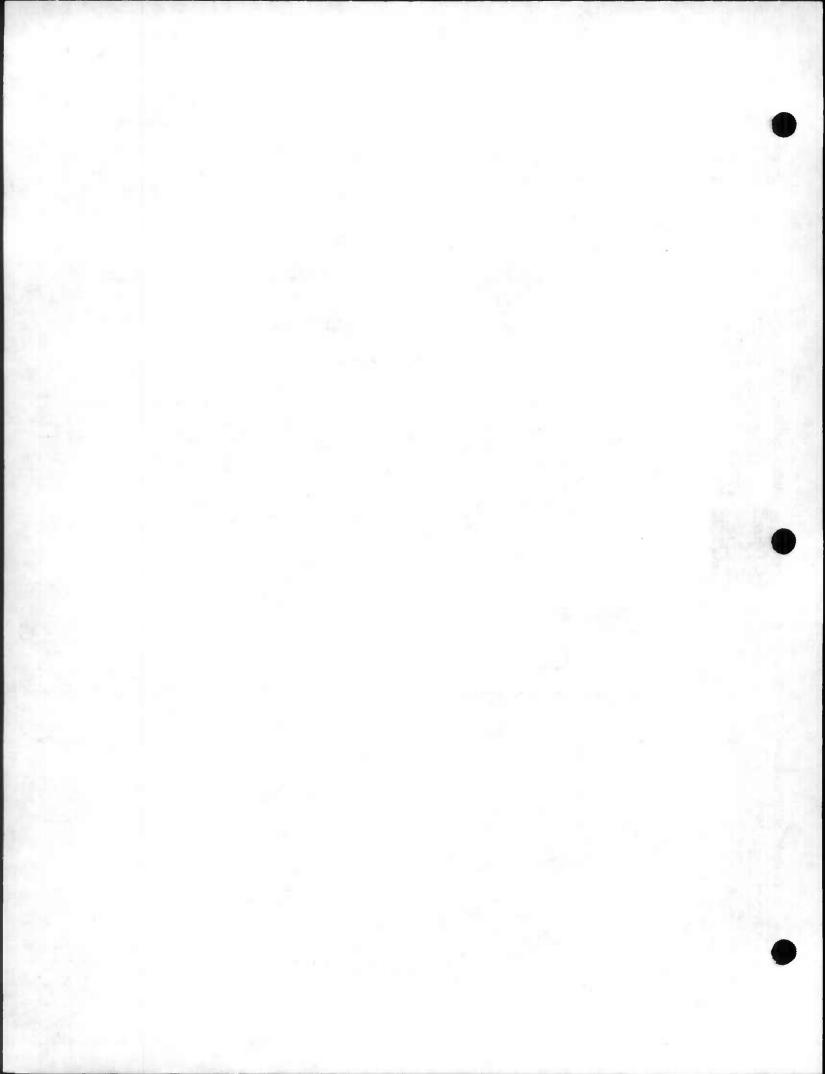


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey **Physician** CARRIE **FOWLKES** 16, 1999 FEB. 1:16AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3822 ELMLEY AVENUE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sax 7. Age (In vrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) Funeral 10 M 25 F Months Days Hours 74 Yrs. Director 579-30-5946-A Usuel Residence of Decedent MARCH 22,1924 NORTH CAROLINA 10a. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits Show 1 Vas 2 No Director MARYLAND BALTIMORE CITY 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code 8 3822 ELMLEY AVENUE 21213 Nerns 23s U.S.A. death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or her important: if Item 27 Is marked other than "natural", or her any injury or other traumatic event, the Medical Exercited Ancel. 1 ☐ Never Merried 2 ☐ Married 1 Yas 2 No If Yas, Giva Yaar or Datas: altimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: þ Specify: AFRO-AMERICAN 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) N/A UNIT CLERK JOHNS HOPKINS HOSPITAL 17. Fether's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be JOHN CARELOCK ANNA DAVIS 2 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) BARBARA A. ELDRIDGE/ NIECE 603 SUNSET DRIVE, MARSHVILLE , NORTH CAROLINA 28103 20b. Piece of Disposition (Neme of 20c. Location - City or Town, Stete 20a. Method of Disposition Dete cametery, cremetory or other piece) 1 Buriel 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) GARRISON FOREST VETERANS CEM. 1999 BALTO, CO, MARYLAND 22. Name end Address of Fecility
CALVIN B. SCRUGGS FUNERAL HOME 21. Signature of Funeral Service Licensee 1412 E. PRESTON STREET MD.21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete fntervel Between Onset end Death **Physician** Amyotrophic Lateral Sclerosis Immediate Ceuse (Final diseese or condition resulting in deeth) /Medical Examiner Due to (or es e consequence of): hysician and the turial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or es a consequence of): Box 68760. Physician/Medical Due to (or as a consequenca of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, ð 24b. Were autopsy findings available prior to Completed 24e. Wes en eutopsy performed? completion of cause of death? 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Aftar 1 Netural 2 Accident 5 Pending investigation 1 Tes 2 No death. n 24 hours after death the Funeral Director: A plately filled in by the f 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 28a. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Phyelclan: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edicai To the Hosp within 24 hor To the Fune complately fi (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 000 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Hillis Johns Hopkins Hospital 31. Dete filed (Month, Day, Year) 32. Registrar's Signetura State 1999 FEB 22 Registrar

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelibie Ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedant's Nama (First, Middle, Last) 2. Data of Daath 3. Tima of Death Day 16 1999 15 pm Mirtle titzp Feb c. County of Death 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Baltanare 15 If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Baltimore ranklin woods Center 7. Aga (In yrs. last birthday) 80 Yrs. If Under 1 Yeer Birthplace (Steta or Foreign Country) 5. Social Sacurity Number Months Devs 1 M 2 F 12/6/1918 214-12-8066 Usual Residence of Decedan Maryland 10a State 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 XYas 2 No N/A Baltimore 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda U.S.A. 21206 4225 Seidel Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Detas: Was Decedant of Hispenic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - American Indien 11. Marital Status 1 Navar Married 2 Married White 1 Yes 2 No Specify: 3 ☐Widowed 4 ☐ Divorced 16a. Dacedent's Usual Occupetion (Give kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Elementery/Secondary (0-12) College (1-4or 5+) Assembly Book Bindery 8 18. Mothar's Nama (First, Middla, Maiden Surneme) 17. Father's Name (First, Middle, Last) Ann (Unknown) John Duff 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 9406 Oak White Road Baltimore, Maryland 21236 Susan Wimmer 20b. Place of Disposition (Nama of 20c. Location - City or Town, State 20a. Mathod of Disposition Gardens of Faith Cemetery 2/18/99 Baltimore, Maryland 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donetion 5 ☐ Other (Specify) John C. Miller Inc. 22. Nama end Address of Fecility 21. Signature of Funeral Service Licens 6415 Belair Road Baltimore, maryland 21206 23a. Part. Enter the disease of complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intervel Batween Onset and Death Immediata Causa (Final disaasa or condition resulting in death) heavet Sequentially list conditions, if eny, leading to immediate ceusa. Entar Undarlying Ceuse (Disaasa or injury that initiated avants resulting in daath) Lest Dua to (or as e consequance of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Onknown 1 Tyes 2 No 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of daath? 1 Yas 2 12 No 1 ☐ Yas 2 ☐ No 26. Placa of Daeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury et Work? 5 Panding invastigation 2 Accidant

requires that the death certificate be exe Division of Vital Records, P.O. Box 68760, signed by the e page 2 hes certificate Hospital or Attending Physician: funeral director, this After

Physician /Medical

Examiner

Physician

/Medical

Examiner

MD

Director

Funeral

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Completed

Be

10

Physician/Medical Examiner

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Completed

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Certification: To

Medical

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mentel Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in Medical Examinal must be notified.

Baltimore, Maryland 21215-0020

25. Was cesa rafarred to medicel exeminar? 1 Yas 2 No 27. Manger of Death 1 Natural

3 ☐ Suicida

29e. Certiflar

4 - Homicida

1 Yas

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Piace of Injury - At homa, farm, straat, factory, office building, atc. (Spacify)

117 Certifying Physician: To tha best of my knowledge, daath occurred at the time, data and place, and due to the causa(s) and mannar es stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred et the time, date and place, and due to the causa(s) end menner stated. (Check only one) 29b. Signature end title of certifie 29c. License number

29d. Data signed (Month, Dey, Year)

30. Nama and addrass of person who completed causa of daath (Item 23a) (Type, Print)

Franklin 05

A.N. Rala pate
31. Dete filed (Month, Day, Year)

1999 FEB 22

32. Registrar's Signetura

#312.

State Registrar

DHMH 16 Rev 6/95

24 hours efter death.

To the Hospital or Atter within 24 hours efter des To the Funeral Director completely filled in by th

2000

6 Could not be datarmined

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 9 0 5 0 8 8

			Certific	ate of Death	Reg	, No. 9 U 3	000	
Physician	1. Decedent's Name (First, Middle, La	st)			2. Dala of Death Month	Dey Year	3. Time of Death	
Physician /Medica	DOTOLDY P. Gladmo	on	FEBRUARY	1 18 1999	1345 HRS			
Examine	4a Facility Nama (If not institution, giv				or Location of Death	4c. County of Death		
1 1 N		PITAL			MORE.			
Funeral Director	=12 03 1107	ex 7. Age (In yrs. 79 79		nder 1 Yaar If Under 24 H ths Days Houra M	in. (Month, Day, Y	(ser) 9. Birthpla Country 1919 Mary		
2 *	Usual Residence of Decedent 10a. Stata 10b. County	10c Ci	ity, Town or Location			110	d. Inside City Limits	
with the Marylan a or 28a-f show Libe notified at				. 7 .		100	1 ☐ Yas 2 ☑ No	
or 28a-f s	MD Baltimon	re	Catonsvi	LITE Zip Coda	100	. Citizen of What Country		
6 2 3 3				21228		USA		
020 urs after aff, or its Examina	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Giva Year or Dates;		ecedent of Hispanic Origin? specify Cuban, Mexican, Pu s 2 No Specify:	(Specify Yea or No- erto Rican, etc.)	14. Race - Amaricar Bleck, While, eli Specify:		
121215-0 ed within 72 ho ed within 72 ho or than "neturn it, the Medical.	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. Decedeni's U	Jsual Occupation work done during most of v	vorkina 16	b. Kind of Businass/Indu	stry	
F 4 4 5 5	Elementery/Secondary (0-12)	College (1-4or 5+)		work done during most of v T use retired)				
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and 2 should be ill sellt and Mental H at 77 in marked off we traumatic even					lame (First, Middle, Ma n E. Price	den Sumeme)		
A DE STORY OF THE	19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Add	rass (Street and Number or	Rural Route Number, C	City or Town, State, Zip C	Code)	
Main a	J. Patrick Ruth (Son)	2108 B	Boston Street	. Unit 412.	. Baltimore.	MD 21231	
or other tr	20a. Method of Disposition 1 Burial 2 Cremation 3	20b. I	Place of Disposition (Name of	Data 20	c. Location - City or Tow	m, Stata	
Haltimor mil. Pages spartment of t portant: if its y injury or of	4 ☑ Donation 5 ☐ Other (Specify			or other place) Ishington Cre		Laurel, Ma		
Ball permit Depart import any in	21. Signature of Furleyat Service Licer			a and Addrass of Facility Edmondson Av		eral HOmes, asville, MD		
	23a. Part1. Enter the disease, or com shock, or heart lailura. List only	plications that caused the dea one ceuse on each line.	th. Do not entar tha r	moda of dying, such as cerd	liac or respiratory errest	i. A	Approximele Intarval Batween Onset and Death	
Physician /Medical Examiner	Immediata Causa (Final disease or condition resulting in death)	a. MYDCARE	0/PL or as a consequence		TION.	<	< 6 HRS.	
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68760, Microste be execut gphysician and as the burishman	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c						
T T D T								
P.O. Box at the death ce is by the attends etached for use		d				1		
0, 4 44	Part II. Other significant conditions of	ontributing to death but not res	sulting in the undarlying	ng causa givan in Part I.		acco use contribute to t		
S. P. P. D.					1 Yes	2 No 3 Probe	ably 45 Unknown	
The law requires also has been signed by page 2 should b					24a. Was an a performe	d? avail	ra autopsy lindings ilable prior to apletion of cause eath?	
He te ha					1 ☐ Yas	2.XNo 1□	Yes 2□ No	
/ital	25. Was casa refarred to medical			26. Placa of C	Death (Check only one)			
T # 06 0		Hospital:	ER/Outpatient 3	Other		ce 6 Othar (Specify)		
		28a. Date of tnjury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how			
Division of the or Attanding P in after death. at Director: Attantised in by the funencentification:	1 Netural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		28I. Location (Street and Number or Rural Route Number, City or Town, State)					
n 24 hours a roading of the Funeral District Medical Co.		yeician: To the best of my kno niner: On the basis of axamina	owledge, death occur ation and/or investigat	red at the tima, data and plation, in my opinion, death oc	ice, and due to the causecurred et the time, date	se(s) and mannar as sta a and place, end due to t	ited. the cause(s)	
P2P2		and manner stated.		29c. License number	204	I. Date signed (Month, Di	lay Vasr)	
ot ot o	Robert	M.0		P-125 98				
1	30. Name and address of person who	completed cause of death (Iter	m 23a) (Type, Print)	015	A	0	141	
	SIMEON K. OBER	15, 5T AGNE	5 Hose,	TRL. YOU CA	FON AVE.	BALTIMUNE	MD.21229	
State	31. Data filed (Month, Day, Year)	32. Registrar's Signa	ature &	South				

THERESA GRAY ITE	MS: #23 PART I, 27 PER	State of Marylan	nd / Depa	rtment of H	lealth and N	Mental Hygie)5089
Physician /Medical	1. Decedent's Name (First, Middle, Las	1)		GRI	47	2. Date of Death Month FEB. 13,	Day Ye 1999	6:13 PM
Examiner	4a Facility Name (If not institution, give BON SECOUR HOSP 5. Sociel Security Number 6. Se	ITAL	. last birthday)	If Undar 1 Yaar	4b. City, Town, or L BALTI If Under 24 Hrs.		4c. County of E	NIA
Funeral Director		M 2×F 3	6 Yrs.	Months Days	Hours Min.	(Month, Day, Te	1962 M	Birthplaca (Stata or Foraig Country) 1 ARY LAN
deeth with the Meryland ma 23a or 28a-f show Linust be notified at neral Director	10a. Stata 10b. County MARYLAND 10e. Street and Number	Citizen of What	10d. Inside City Limit 1 Yes 2 □ N Country?					
urs after br, or ite Examine by Fui	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 DNo If Yas, Give Year or Detes:	If	as Decedent of H Yes, specify Cubi	2123 dispanic Orlgin? (Span, Mexican, Puerto Specify:	pecify Yes or No- p Ricen, etc.)		American Indian, /hite, etc.
	15. Decedent's Ed (Specify only highast grade Elementary/Secondary (0-12)	ucation de com <i>pleted)</i> College (1-4or 5+)	16a. Decede (Give k life. De	ent's Usual Occup ind of work done O NOT use retired	during most of won d)	king	o. Kind of Busine	
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d 2 should be file the and Mentel Hy I is marked oth traumatic event To Be	MELVIN 19a. Informant's Name/Relationship (7	I DUI	19b. Mailing	Addrass (Street	and Number of Ru	ral Route Number, C	MILE lify or Town, Sta	
Pages 1 an ent of Heal ht: If Nem 2 ry or other	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from Stata	TZ10	etory or other pla	ce)		E, MD. 6. C. Location - City	
permit. Pa Departmen Important: any Injury.	Signature of Futeral Service Liceo Service Liceo Service Liceo Service Liceo Service Liceo Service Liceo Service Liceo Service Liceo Service Liceo Service Liceo Service Liceo	lications that ceused the dea	1	Name and Address SEPH 140 N r the mode of dyin	H, BRO FULTO ng, such as cerdiac	OWN JR. I N AVE. or respiratory arrest	FUNER BALTIA	WNE, HARYLA CAL HOME WRE, MD, 2/21 Approximate Interval Between
Physician /Medical Examiner	Immadiate Cause (Final disease or condition resulting in deeth)	a. HY	PERTENSIV		ASCULAR DIS	EASE		Onset and Death
be executed sicien and bunal-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying	b. Due to (or as a consequ	ence of):				
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The law requires the cate has been signed pege 2 should be completed by						24e. Wes en a performe		4b. Were eutopsy findings available prior to completion of cause of deeth?
The peg	05.10					Yes	2□ No	Yes 2□ No
Physician: this certific ral director,	25. Was cese referred to medical examiner? 1. ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2€	XER/Outpatient	3□ DOA Oth	or.	ith (Check only one) ome 5 Residence	e 6 Other (Specify)
Ing Ph. After the funeral	27. Manner of Death 1 Matural 2 Natural 3 Pending investigation	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Inju		28d. Describe how		
or Attended to the control of the ctor: d in by the	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, stre	et, factory, office		28f. Location (Stree City or Town, S	et and Number of Stete)	r Rural Routa Number,
Hospital 24 hours e Funeral Dietaly filled		raician: To the best of my kn- iner: On the basis of examin and manner stated.						

State Registrar

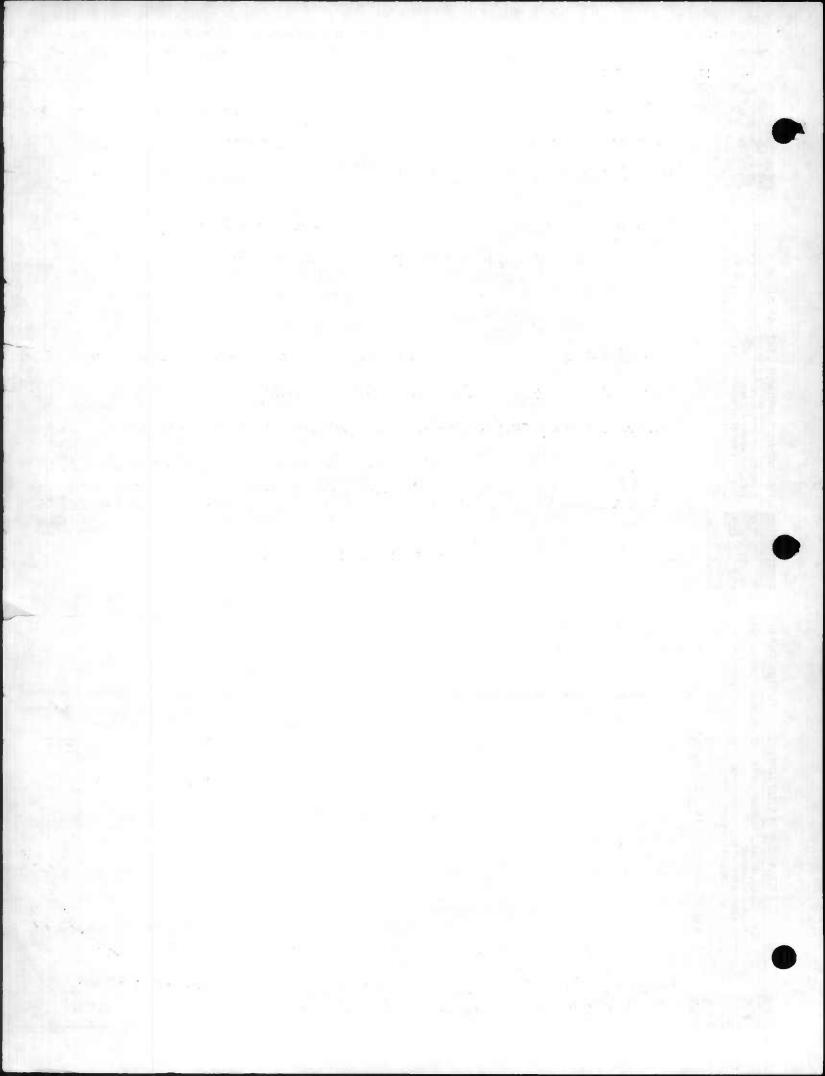
ed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year) FEB 14, 1999



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Beulah Geatins 19 1999 February 2:28 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Eastpoint Nursing Home Baltimore Eastpoint If Under 24 Hrs.
Hours Min.
Sept 21 19 ff Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1□M 2XF Months 219-10-9891 Vrs 84 Director 1914 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "netural", or items 23s or 28s-f show 1 ☐ Yes 2 No Director MD Baltimore Dundalk 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 8212 Peach Orchard Rd 21222 death v USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 21 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White py 3 XWidowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Manager 18. Mother's Name (First, Middle, Maiden Sumame) permit. Peges 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 is marked other any injury or other treumetic event pace. 17. Father's Name (First, Middle, Last) Quinter Russell Anna Mae Bagley 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) James Van Tassel 8212 Peach Orchard Rd /son Baltimore, MD 21222 20b. Place of Disposition (Name of cemetery, cremetory or other place) Feb 24 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 1999 Arlington National Arlington, VA 22, Name and Address of Facility
Connelly Funeral Home of Dundalk 21. Signature of Funeral Service Licenses 23a. Pert1. Enter the disease, or applications that caused the deeth. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical Examiner Examiner 1 Levis Scler va physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy 1 Yes 21 No 1 Yes 2 No 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred edical Certification: 28c. Injury at Work? After t To the Hospital or Attending 5 Pending Investigation 1 Yes 2 No death. within 24 hours after death To the Funeral Director: / completely filled in by the f 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signeture end fifte of Conflict 29c. License number 29d. Date signed (Month, Day, Year) wo RED 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ECLWOOD AUG, BALTO, MD21224 MELITO M. TORNES, MO 441 5.

DHMH 16 Rev 6/95

State

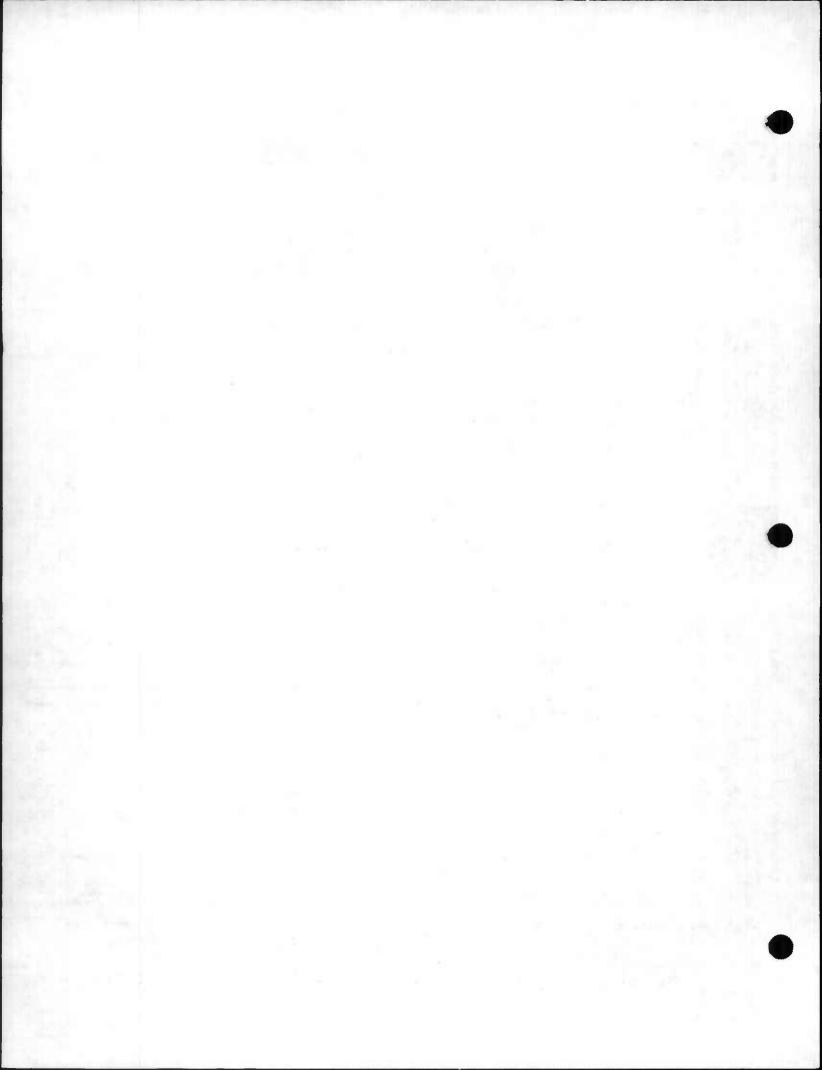
Registrar

31. Date filed (Month, Dey, Year)

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32 Registrar's Signatu

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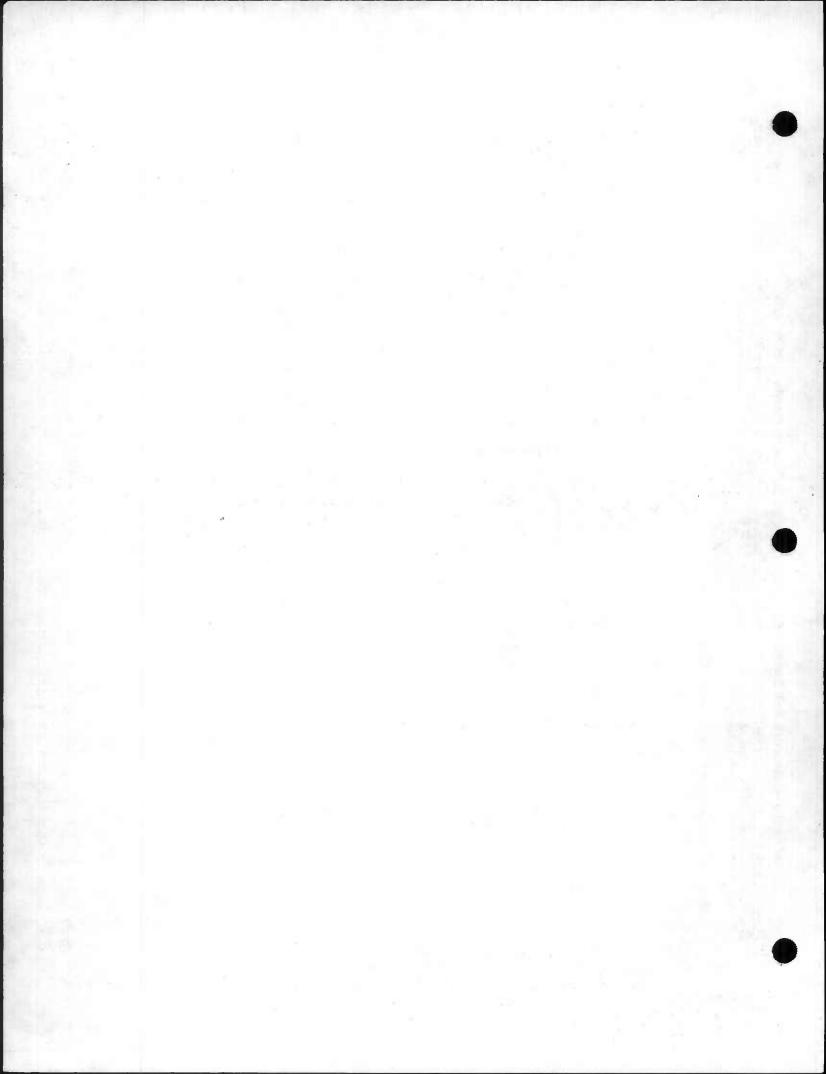


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Amended#24a perPhyG768 2/22/99 EW Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death HOLDEN February 10, 1999 **Physician** JEAN TODD 6:15 AM /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Name (If not institution, give street and number) Examiner 101 Eastern Avenue Bel Air Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 23, 1916 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** Days Months Hours 1□ M 20 F 82 Country) Virginia 217-12-5747 Yrs. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City I Imits r than "natural", or itema 23a or 28a-f ahow the Medical Examinar must be notified at Director 1 Yes 2 No Bel Air Maryland Harford 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 101 Eastern Avenue 21014 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or item any injury or other traumatic avent, the Medical Example page. Black, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baitimore, Maryiand 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White ò 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) unknown unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Gwynne L. Holden unknown 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Todd Holden/son 101 Eastern Avenue, Bel Air, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 45 Donation 5 ☐ Other (Specify) 21 Superfure of Funeral Service Licensee
Ronald S Nade Director 22. Name end Address of Facility
State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and the cause of the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and the cause of the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and the cause of the death. Approximate Intervel Between Onset end Death **Physician** Metastatic Colon Cancer /Medical Immediate Cause (Final years disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditiona, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last Due to (or as e consequence of): P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ata has been signed by page 2 should be detac 1 Yes 2 No 3 Probably 4 Unknown þ Records. 24b. Were autopsy findings available prior to Completed 24a. Was en eutopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata Division of Vitai or Attanding Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 ENetural 5 Pending investigation 1 Tyes 2 No 24 hours after death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29e. Certifier Medical (Check only one) Within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 135012 30. Nems and andress of person who completed cause of death (Item 23a) (Type, Print) North Ave. BelAir, Md, 21014 Lynch Kevin MO 2 31. Dete line (Month, Day, Year) 32. Registrar's Signature State FEB 22 Registrar

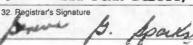


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31. Date filed (Month, Day, Year) State Registra

HARYSMOD What 111 Penn Street, Baltimore, Maryland 21201 FEB 2 0 1999

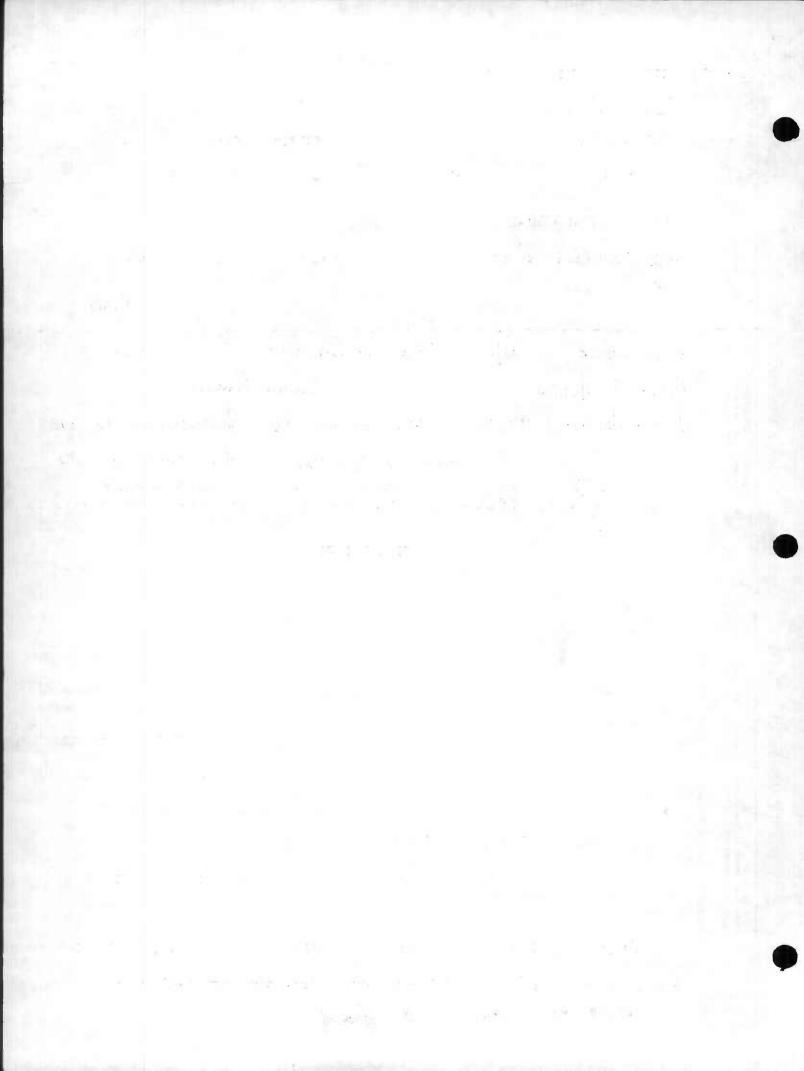
30. Neme end address of person who completed cause of death (Item 23a) (Type, Print)



OCME

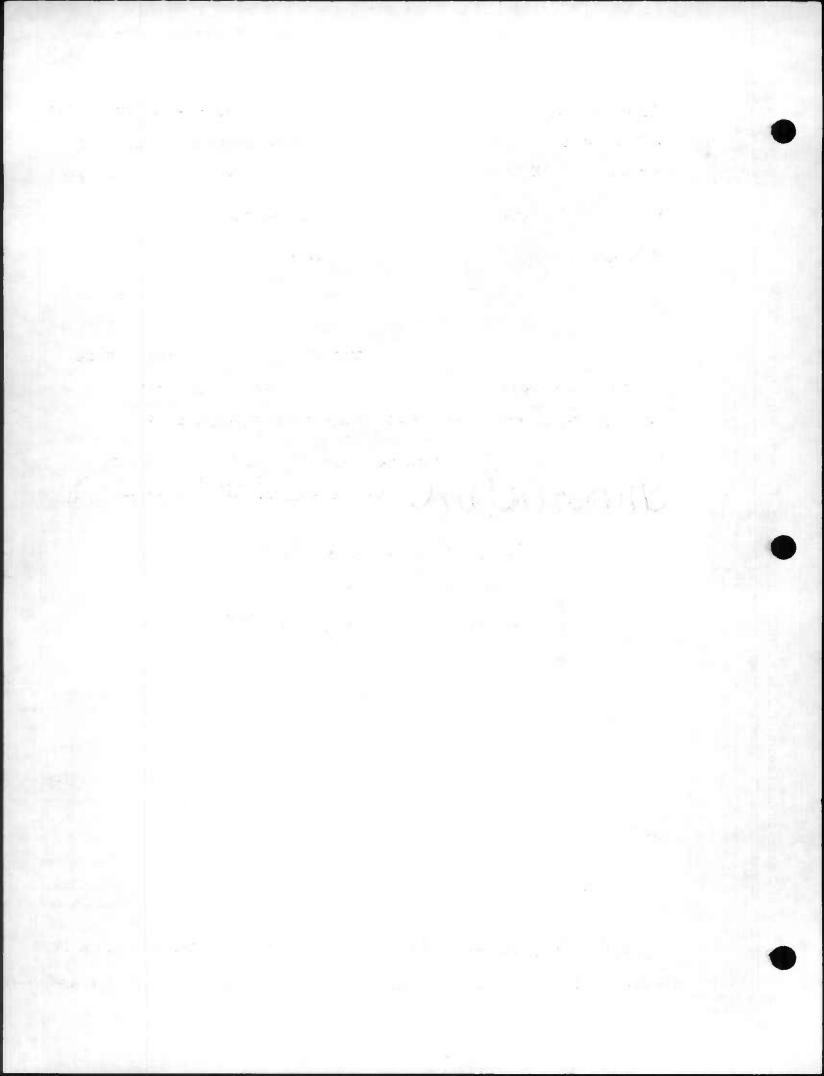
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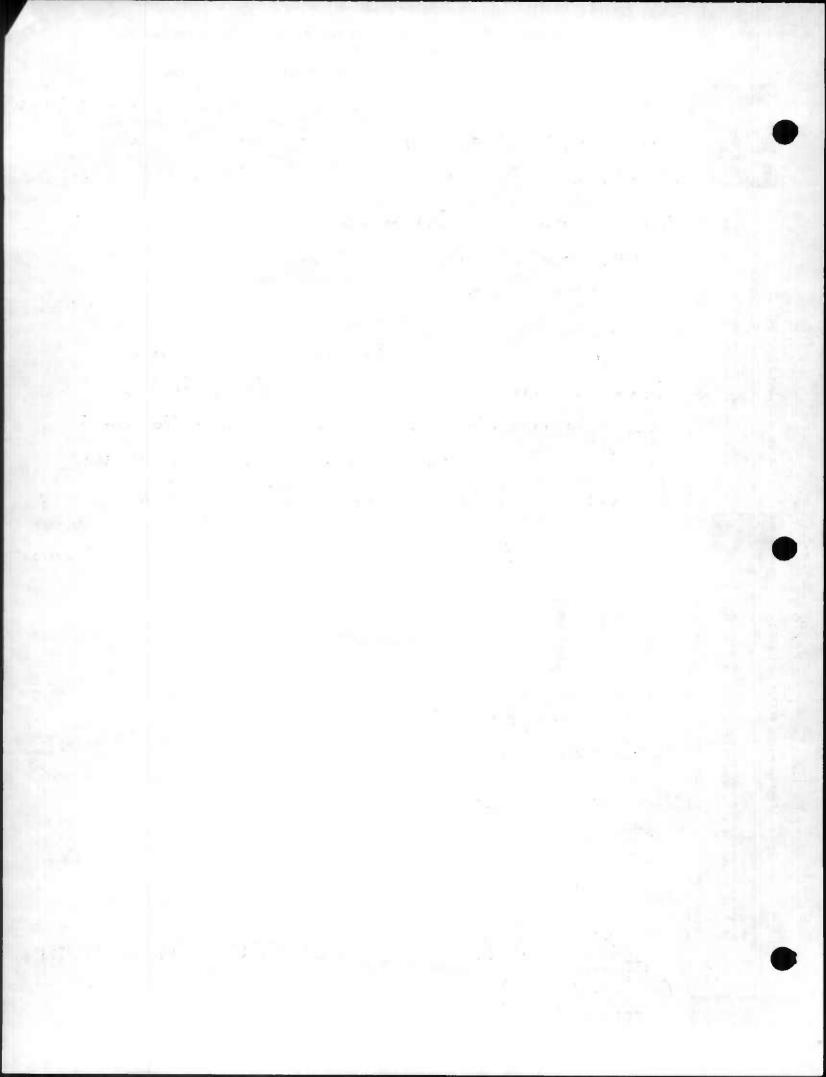
State of Maryland / Department of Health and Mental Hygieneg 9 05093

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day Yaar **Physician** Haskins 2:25 AM February 1999 obert 19 a /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number, 4c. County of Death Examiner Horpita If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 402 Baltimore Galtimore N/A Sirai 6. Sax If Undar 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** Months Days 1 M 20 F Yrs. 213-01-9492 Usual Residence of Decedent Director 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Baltimore Md 1¥ Yes 2□ No Director 8 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? r then "natural", or items 23s or the Medical Examiner must be a U.S.A 5015 21215 unset Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 Black þ 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) 1 and 2 should be filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Domestic Home marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be h and Mental i Hawkins Bett James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routé Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Nem 27 is Balta Sunset niece 5015 Md. 21215 yarrison 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 8 24 Md Natih Cemetery 4 ☐ Donation 5 ☐ Other (Specify) haurel 21. Senature of Funeral Service Licenses 22. Nama and Address of Facility Sons 1 A. James Mor Balto, Md St. Laurens 21217 1701 23a. Part. Enter the diseasa, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Daath **Physician** /Medical Immediate Cause (Final neumonia 2 weeks disease or condition resulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner certificate be executed ettending physician and for use as the buriel-trans Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consaquence of): 88 Box Part II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the cause of death? the signed by t 3 Probably 4 ☑ Unknown ttypertension, Renal Failure 1 ☐ Yes 2 ☐ No LNOWN Completed by 24b. Were eutopsy findings available prior to complation of ceuse of deeth? Cerebro Wascular accident, Breast Cancer 24a. Wes an autopsy 1 Yes 2 - No 1 Yes 2 No this certificate of Vital 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 2 20 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Menne of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After t 5 Pending invastigation Division or Attending 1 Natural a Funeral Director: Aft of Funeral Director: Aft ofetely filled in by the fur 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner es steted. Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture and title a certifier 29c. License number 29d. Date signed (Month, Day, Year) -000 eand address of person who completed cause of death (Item 23a) (Type, Print) - Marder 31. Date filed (Month, Day, Year) Registrar's Signature State FEB Registrar

DHMH 16 Ray 6/95

Husku



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Feb ruary **Physician** 9:10P 18 Frances Eileen /Medical 4a Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Deeth' 4c. County of Deeth Examiner Fallston General Hospital Fallston Harford If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (Stete or Foreign Country) **Funeral** 1 □ M 2 X F Months 83 Yrs. **Director** 215-01-6449 12, 1915 Maryland parmit. Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Haath and Mantal Hygiana. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Directo Maryland N/A Baltimore 10e. Street and Number 10g. Cifizen of Whet Country? 10f. Zip Code 2044 Swansea Road 21239 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1 ☐ Yes 2 No If Yes, Give Yaer or Detes: 1 Never Marriad 2 Married 1 ☐ Yes 2 XNo Specify: Specify: p White 3 DWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 10 Secretary Custom Tailoring 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maidan Sumama) Α. Maskell James Annie Odelia Baxlev 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) / Son Michael D. Hires 1302 Boggs Road Forest Hill, Maryland 21050 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 X Burial 2 Cremetion 3 Removel from State 2/22/99 Parkville, Maryland Parkwood Cemetery 4 Donetion 5 Othar (Specify) 22. Neme end Address of Fecility Timothy Harman Leonard J. Ruck, Inc. Funeral Home 5305 Harford Road Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each line. Approximete Intervel Batween Onset end Deeth Immadlate Cause (Final diseese or condition resulting in deeth) > Syears Dua to (or as a consequence of): Examiner Sequantielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or es e conseguança of): Physician/Medical Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy findings available prior to completion of cause of deeth? leted 24a. Wes en eutopsy 2 No 1 ☐ Yas 2 ☐ No

Physician /Medical Examiner

attanding physician and for usa as the burial-transit Tha law requires that the death certificate be executed

Aftar this cartificata has I funaral director, paga 2 s

Certification:

Compl Be To

Division of Vital Records, P.O. Box 68760, or Attending Physician: 2

aftar

within 24 hours a To the Funeral C complataly filled Hospital

filled in

Frances

29e. Certifier Medical (Check only

4 Homicide

28e. Dete of Injury (Month, Day Yeer)

5 Pendina 6 Could not ba

Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA

28b. Time of Injury

1 ☐ Yas 2 ☐ No 28e. Plece of Injury - At home, farm, streat, factory, office building, etc. (Specify)

26. Placa of Death (Chack only ona) Other: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Other (Specify) 28c. Injury et Work? 28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stefe) 1 Certifying Physician: To the best of my knowladga, daath occurred at the time, date end plece, end due to the cause(s) and menner as steled.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner steled.

29b. Signetura end titla of certifier

25. Wes case raferred to medical examiner?

1 Yes 2 No

27. Menner of Daath

1 Naturel

2 Accident

3 ☐ Suicide

29c. License number

29d. Date signed (Month, Dev. Year)

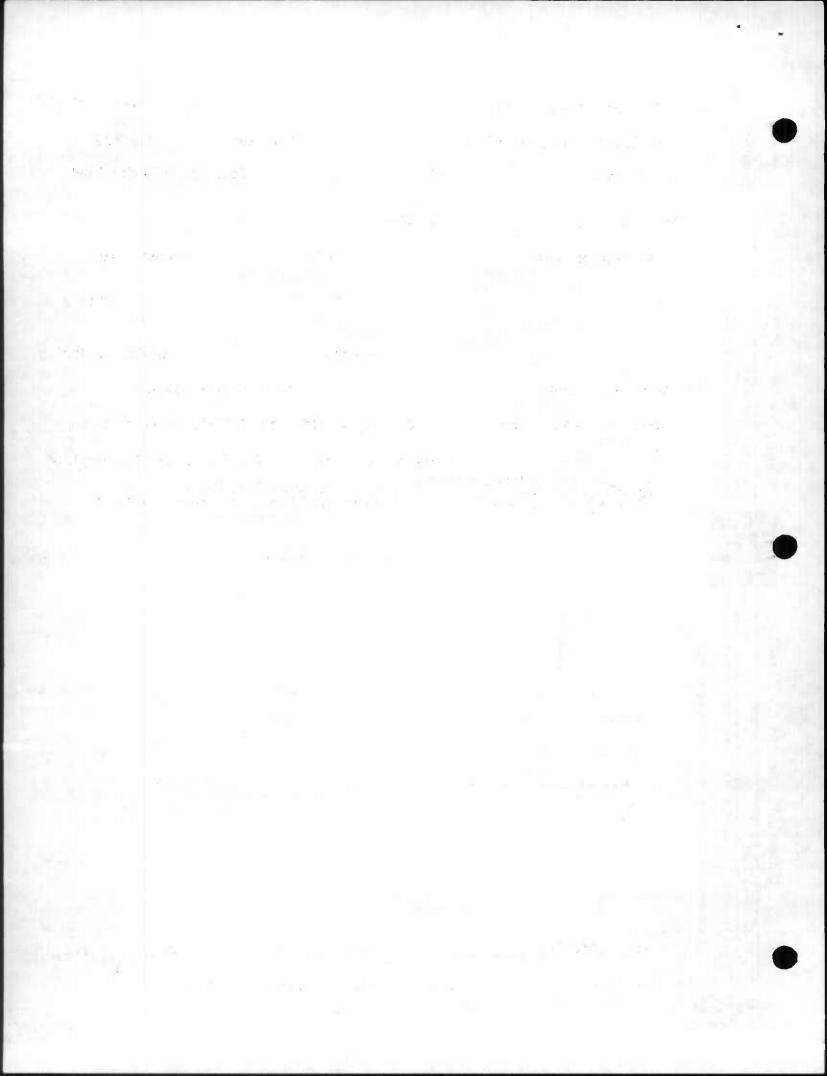
30. Name end eddrass of person who completed cause of death (Item 23a) (Typa, Print)

6,5 WOST MACPhai 2

Bel Air, Maryland

Registrar

32 Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey **Physician** GEORGE HOLMES 11:16 PM FEBRUARY 19 1999 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner JOHNS HOPKINS HOSPITAL paltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dale of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 10 M 20 F 75 Yrs. SEPT. 5, 1923 MARYLAND Director 214-18-9991 Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show Yes 2□No MARYLAND N/A BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 'natural', or items 23s 1625 E. PRESTON STREET 21213 U.S.A. Funeral Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: AFRO-AMERICAN 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'a Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 6TH BARTENDER SELF EMPLOYED N/A permit. Pages 1 and 2 should be list.
Department of Health and Mental Hy importants if them 27 is marked other any Injury or other 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be GEORGE HOLMES LULA DAVIS 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE H. HOLMES, III/SON 400 E. 27TH STREET BALTIMORE, MD. 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 Donetion 5 DOther (Specify) ZION CEMETERY FEB. 25,1999 BALTIMORE, MD. 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME 21. Signature of Funeral Service Licensee 21213/ 1412 E. BALTIMORE, MD. 23a. Part1. Enter the disease, or complications that caused to be able to be a complication of the complete the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each limit Approximate Interval Between Onset end Death **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical GASTROINTESTINAL BLEED HOURS Examiner Due to (or es a consequence of): MEEK ANTICOAGULATION physician and sthe burief-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): STROKE WEEK Box 68760 edical Due to (or as e consequence of): Physician/M Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 3 Probably 4 Unknown 1 Yee 2 No FIBRILLATION ATRIAL by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? Completed EMPHYSE MA 1 Yes 1 Yes 2 No certificate of Vital 25. Wes case referred to medical examiner? 8 26. Place of Death (Check only one) 1 Yea 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 10 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? After Division or Attending Neturel 5 Pending investigation n 24 hours after death.

Funeral Director: After the function of the function 1 Yea 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled is Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edical 29e. Certifier (Check only one) 29b Signature and uple of certifier 29c. License number 29d. Date signed (Month, Day, Year) FEBRUARY 20, 1999 RES-000 M.D. ROTHA 30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print) JOHNS HOPKINS HOSPITAL BROTMAN DANIEL 31. Dete filed (Month, Day, Year)

DHMH 16 Rav 6/95

State

Registrar

FEB 2 2 1999

ORIGINAL

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32. Registrar's Signature

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Registra

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

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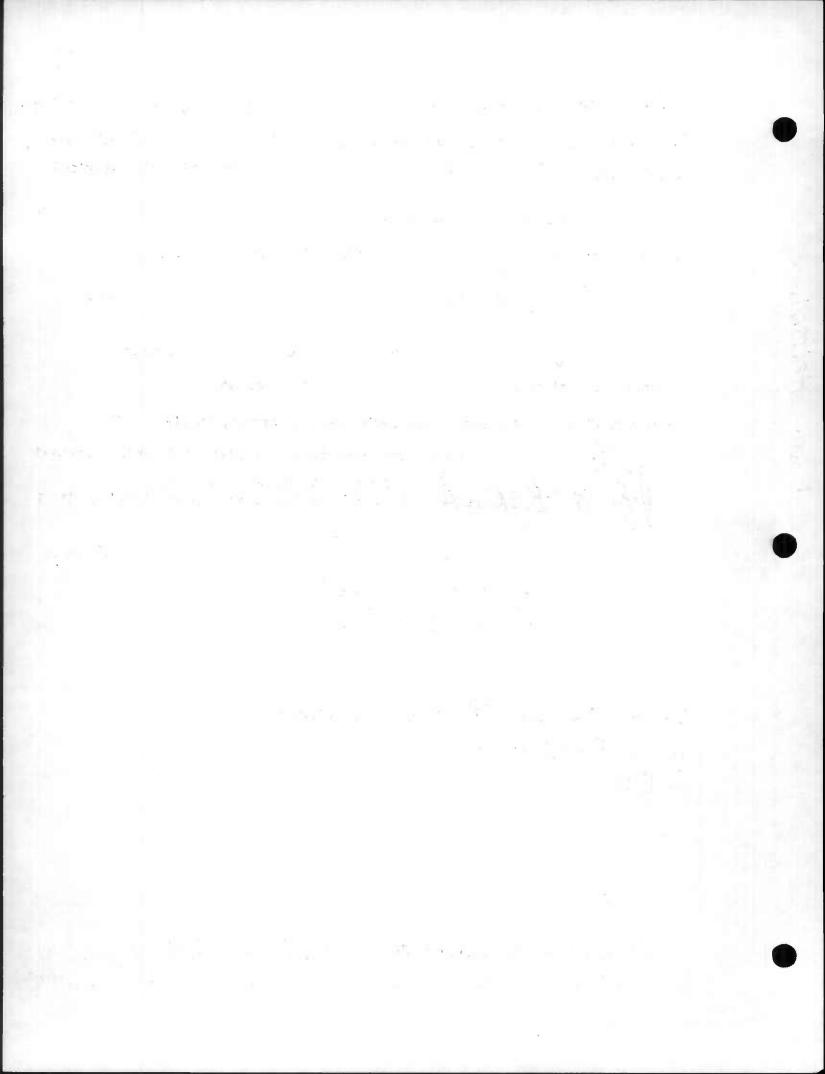
Daniel

31. Date filed (Month, Dey, Year)

9000 Franklin

32. Registrer's Signeture

Square Drive Baltimore, Maryland 21237



99-0910-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibie.

WILLIAM HEDRICK

State of Maryland / Department of Health and Mental Hydiene

If Under 1 Year

Deys

Months

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ertificate of Death	
Fillicate of Death	Reg. No.

Physician
· /Medical
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Examiner

1. Decedent's Name (First, Middle, Last)

SHOCK TRAUMA CENTER

2. Dete of Deeth Month Dey 17,1999 FEBRUARY

3. Time of Death

William Lee Hedrick 4e Fecility Neme (If not institution, give street and number)

4b. City, Town, or Location of Deeth

BALTIMORE

4:14P.M. 4c. County of Deeth

29d. Dete signed (Month, Dey, Year)

FEBRUARY 18,1999

111 Penn Street, Baltimore, Maryland 21201

Funeral

5. Social Security Number

235-30-3226

XXM 20 F 73

7. Age (In yrs. lest birthday)

If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Dey, Year) May 13, 1925 9. Birthplece (Stete or Foreign Country) West Virginia

Director

with the Merylend iral", or items 23s or 28s-f show Examiner must be notified at death

Health Herm 27 B

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

29a. Certifier

29b. Signeture end title of certifier

31. Dete filed (Month, Day, Year)

HEODORE

FEB 22

30. Neme end eddress of person who completed ceuse of death (Item 23e) (Type, Print)

1999

32. Registrer's Signeture

Medicai

State

Registrar

To the Hospital or Attending Physician: The law requires the within 24 hours after death.

within 24 hours after death.

The Funeral Director: After this certificate has been signed completally filled in by the funeral director, page 2 should be completally filled in by the funeral director, page 2 should be.

Division of Vital Records, P.O. Box 68760,

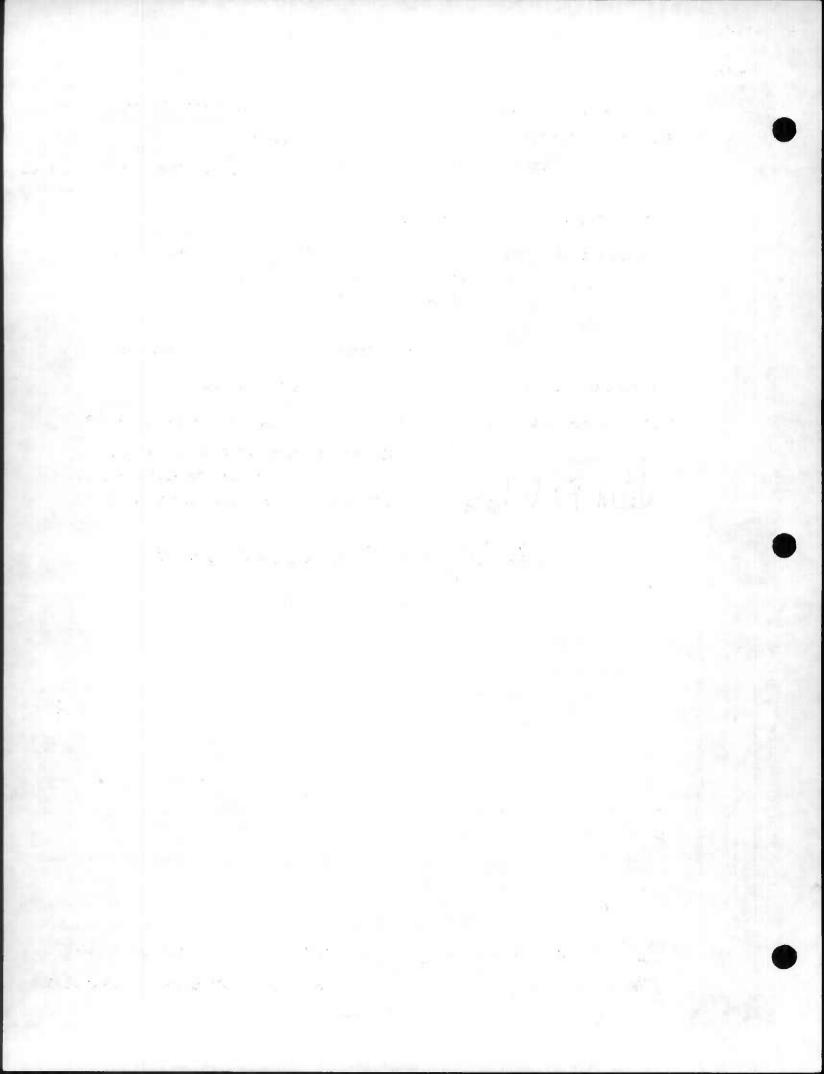
	Canal Healderice of Decedent										
	10e. Stete 10b. County	/	10c. City	y, Town or Loca	ition					10d. Inside City Limits	
TOL	Maryland Balt:	imore	Ba1	timore						1 ☐ Yes 2 H No	
6	10e. Street end Number	4 - 11 18 - 1		100	10f. Zip Co	ode		10g. C	itizen of Wi	het Country?	
5	914 Maiden Che	oice Lane		H1		21229		Uni	ted S	States	
	11. Marital Status	12. Wes Deceder Armed Force	nt Ever in 15	\$13 13. Wa	as Deceden	t of Hispanic Or Cuben, Mexica	Igin? (Specify n, Puerto Ricar	Yes or No- n, etc.)		- American Indien, , White, etc.	
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חב בחווחובובת	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Educetion est grede completed)	. 5.1	18e. Deceder (Give kii life. DC	nt's Usuel C nd of work of NOT use	done during mos	t of working	16b. F	(Ind of Bus	siness/Industry	
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	17. Fether's Name (First, Middle,	, Lest)			7111	18. Moth	er's Name (Fir	st, Middle, Malde	n Sumeme)	
	Raymond Lee H	edrick				Myr	tle Mu	11enax			
	19a. Informent's Name/Reletion:							ute Number, City altimore			
-	Marion Hedric 20a Method of Disposition	K (MITE)	20b. P	lace of Disposit						City or Town, Stete	
	12D Burial 2 □ Cremation 4 □ Denaton 5 □ Settler (5	3 □Removal from Star Specify)	C	emetery, crema	tory or othe	orial Gard				am, MD	
-	21. Signature of Funeral Service	License		22.1	Neme end /	Address of Fecili	y Ambro	se Funer	al Ho	ome, Inc.	
1	> VOOU Y	3druhis	All	13	28 Su	libhur Se	oring R	oad Arbu	itus.	MD 21227	
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- International	d										
	Part II. Other significant conditi	ons contributing to death	but not resu	ulting in the und	erlying ceu	se given in Pert	l.			tribute to the cause of death	
								24e. Wes en euto performed?	opsy	24b. Were eutopsy findings eveilable prior to completion of cause of deeth?	
								1 Yes	2□No	1 Yes 2□ No	
	25. Wes case referred to medical examiner?						e of Deeth (Ch	eck only one)		1	
	1⊠ Yes 2□ No			ER/Outpatient				5 ☐ Residence			
	2 LI Accident	igation	njury Day Year)	28b. Time of Injury	28c	Injury at Work? 1 Yes 2		Describe how Inju	ury occurre	od	
	3 Suicide 6 Could 4 Homicide determ	nined 256. Pleca of	Injury - At ho etc. (Specif)	ome, farm, stree	et, fectory, o	ffice	28f. I	ocation (Street a City or Town, Ste	and Numbe (e)	r or Rural Route Number,	

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete and plece, end due to the cause(s) end menner stated.

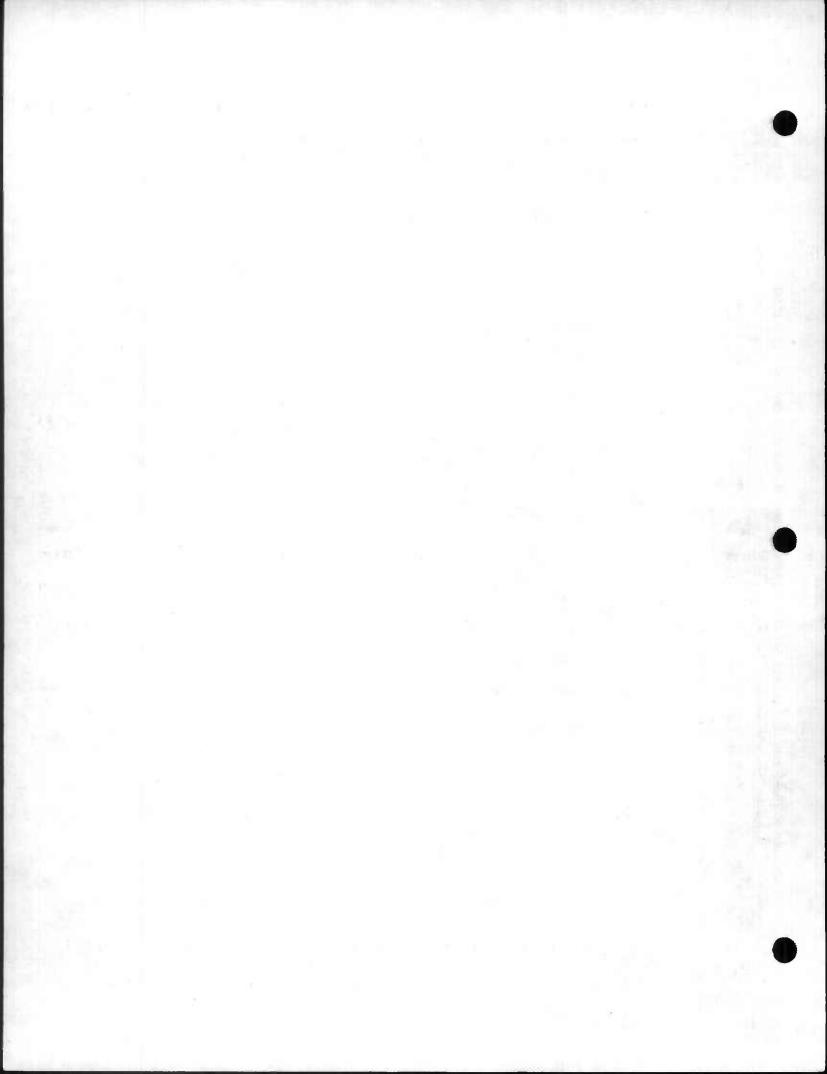
29c. License number

O.C.M.E.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					Certificate o	f Death	Reg	ı. Nd.	05099
	Dhuaisi		Decedent's Nama (First, Middle, Last)				2. Data of Death Month	Day	3. Tima of Death
	Physicia /Medic		MABLE JON	ES	14-7-37-29		FEBRUALL		199 3:02 p.m.
	Examin		a Facility Name (If not institution, give street		1 1	4b. City, Town, or Lo		4c. County of	of Death
			UNIVERSITY of MARY!	i i		Balhno	re		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday) If Under 1 Ye. Months Day	ar If Under 24 Hrs. ys Hours Min.	8. Data of Birth (Month, Day,	(agr)	9. Birthplace (Stata or Foraign Country)
ш	Director		220 - (8-6976 Usual Residence of Decedent	/ //			3-7-1	726	Pla
	yland Mand		IOa. Stata 10b. County		y, Town or Location				10d. Inside City Limits
	Med	tor	Md NA	Ba	eltimore				1 TYas 2 □ No
	2 th	Director	I Oe. Street and Number		10f. Zip Code	9	100	. Citizen of W	hat Country?
	72 hours after death with the Meryland neturel, or flems 23e or 28e-f ehow deel Exempler mast be notified at		827 N. Arlington	Avenue	2	1217		U.	5.4
	r de	Funeral	A	as Decedent Ever in U med Forces?	S. 13. Was Decedent of If Yes, specify C	of Hispanic Origin? (Speuban, Mexican, Puerto	city Yas or No- Rican, etc.)		- American Indian, , Whita, atc.
20	9 4	by F	1 Never Married 2 Married 1 If 3 Widowed 4 Divorced Y	Yes 2 No Yes, Give ear or Dates:	1□ Yes 2001	lo Specify:		Specify:	Rlado
5-0020	natural',	D D	15. Decedent's Education		16a. Decedent's Usual Occ	numation.	146	h Kind of Bu	Siness/Industry
215	S 1.8	Completed	(Specify only highest grade com	pleted)	(Give kind of work dor lifa. DO NOT use ret	ne during most of worki	ng	io. King or but	siness/ii oustry
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ore		1	20a. Mathod of Disposition 1 X Burial 2 Cremation 3 Remov		lace of Disposition (Name of emetery, crematory or other p				City or Town, Stata
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			23a. Part1. Entar the disease or complication shock, or heart tailure. List only one can	ns that caused the deat use on aach line.	h. Do not enter tha mode of o	tying, such as cardiac o	r raspiratory arres	t,	Approximate Interval Between
F	Physician /Medical		Immediata Causa (Final						Onset and Death
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8	2 2 2	Per	resulting in death) Last						
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5	ysicien: The s cartificeta director, pag	0	25. Was casa referred to medical examiner?	al·	1	26. Place of Death Other:	(Check only one)		
ō	0 0	၉	TE TOS ALEXAGO	a. Date of Injury	ENVOUSPBILIEFIT 3 DOA	4 U Nuising Ho	ne 5 Residen 28d. Describe how		
uo .	After fune	Floa	Natural 5 □ Pending	(Month, Day Year)	Injury V	Vork? ☐ Yes 2 ☐ No	LOG. Describe now	injury occurre	
Division	deat ctor: y the	fice	3 Suicide 6 Could not be	e. Place of Injury - At he	ome, farm, street, factory, offic		28f. Location (Stre	et and Numbe	or or Rural Route Number,
á.	Dia	Certification:	4 Homicide	building, etc. (Specif	v)		City or Town,	State)	
	To the hopping of Arending Phy within 24 hours efter death. To the Funeral Director: After thi completely filled in by the funeral	<u>e</u>	29a. Certifier 1 Certifying Physician	To the best of my kno	wledge, death occurred at the	tima, date and place, a	and due to the cau	se(s) and mar	nner as stated.
:	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	edical	(Check only 2 Medical Examiner: Cone)	n the basis of axamina nd manner stated.	tion and/or investigation, in m	y opinion, death occurre	ed at the time, dat	a and place, a	nd due to tha cause(s)
	To He Ho		9b. Signatura and titla of certifier			ense number			(Month, Day, Year)
			Mazzettel)	BNOENT PI	tysician Le	38485	7	bran	17,1999
	3		O. Name and address of person who complet						
	/		NAZARIAN 7		NEST BALT	MORE, M	tey LAND	2120	1
	Stat	٠	11. Dala filed (Month, Day, Year)	32. Registrar's Signa					
	Registra	r	FEB 2.2 1999	101	La laboration				



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Tima of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death Yaar G G **Physician** OUN SON 22:47 HEODOLE teb /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva straat and number) 4c. County of Death Examiner LIBERTY MEDICAL CENTER BALTIMORE CITY N/A 7. Aga (In yrs. last birthday) If Under 1 Year If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (Stata or Foreign **Funeral** 1 □ 3013/2 □ F 66 Yrs. 9 212-30-3073 AUG SOUTH CAROLINA Director Usual Rasidance of Decedant Pages 1 and 2 should be filed within 72 hours efter death with the Menylend nent of Heelih and Mental Hyglene. Int: If item 27 is marked other than "natural", or items 23a or 28e-f show my or other transmit or notified any or other transmits event, in a langual cast and the notified as 10a State 10h Counts 10c. City, Town or Location 10d. Insida City Limits 1XX as 2 □ No BALTIMORE CITY Directo MARYLAND N/A 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? "natural", or items 23s or bolical Examiner must be a 2005 N MONROE STREET 21217 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armad Forcas? 1 ☐ Yes 2 ZNo If Yas, Give Yaar or Datas: 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian. Black, Whita, atc. 1 Nevar Married 2 Married 1 Yas 2 No Baltimore, Maryland 21215-0020 Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highast grade complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collaga (1-4or 5+) 12yrs PAINT MIXING TECHNICIANS DECORATIONS 17. Fathar's Name (First, Middla, Last) 18. Mothar's Name (First, Middla, Maiden Sumama) Be THEODORE JOHNSON REBECCA ANN WALKER 19b. Meiling Addrass (Streat and Number or Rural Routa Number, City or Town, State, Zip Code) 21217 2005 N. Monroe St., Baltimore, Maryland 19a. Informant's Name/Relationship (Type, Print) ANNIE V. Johnson/Wife 20a. Method of Disposition 20b. Placa of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata Department of Important: If it any injury or o 1 Burial 2 Cramation 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE CEMETERY 2 - 25BALTIMORE, MARYLAND 22. Nama and Addrass of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME 1206 W NORTH AVENUE Manera PA 23a. Part. Phiar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximata Intarval Batween Onsat and Death **Physician** /Medical Immediate Ceuse (Finel disaasa or condition rasulting in daath) Examiner Examiner Sequantially list conditions, if any, laading to immediata causa. Entar Undarlying Cause (Disease or injury that initiated avants resulting in daath) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760 **Physician/Medicai** Due to (or as a consequence of) 80 987 signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the causa of death? 3 Probably 4 Unknown 1 ROKE 1 Yes 2 No à 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of causa of death? ate hes page 2 s 2 0 No certificate 1 ☐ Yas 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician: director, 25. Was casa refarred to medical Be 26. Place of Death (Check only ona) axaminer? 1 Ves 2 No Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 2 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Menner of Death 28e. Dete of Injury (Month, Day Yaar) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Panding efter death. Director: Aft 1 Yes 2 No invastigation 2 Accidant 6 Could not be datarminad 28a. Place of Injury - At homa, farm, straet, factory, offica building, atc. (Spacify) 3 Suicide 28f. Location (Street and Numbar or Rural Route Number, City or Town, Stata) filled in by 4 D Homiclda 24 hours e 29a. Certifier 1 👺 Certifying Physician: To the best of my knowladga, daath occurred at the tima, deta and place, and dua to tha causa(s) and mannar as stated. Medicai To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of axeminetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) end mannar statad. 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 30. Name and address of person who complated cause of death (Item 23a) (Type, Print)

LIBERTY

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State

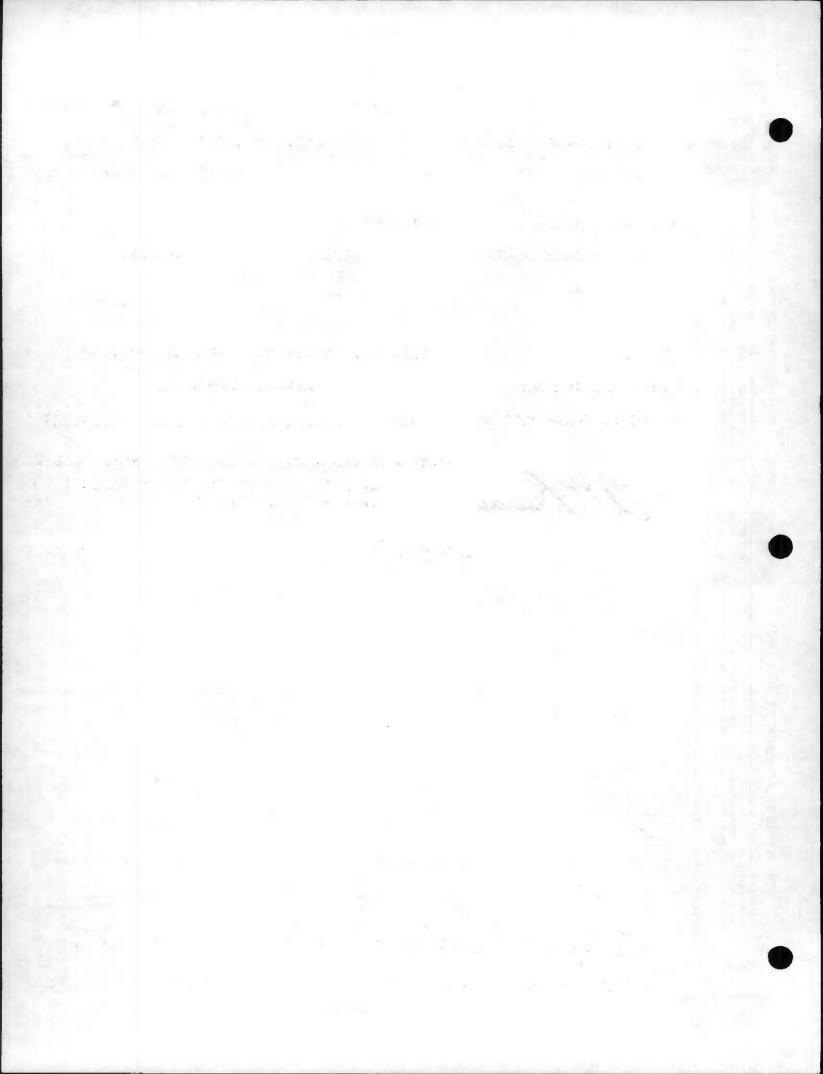
Registrar

22540240

32. Ragistrar's Signature

31. Data filed (Month, Day, Year)

FEB 2



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Data of Death 3 Time of Deeth **Physician** 1:25 Am Facility Nama (If not institution, giva street and number) /Medical 4b City, Town, or Location of Deeth 4c. County of Death Examiner 6. Sex Care Baltimore Ider It Undar 24 Hrs. 8, Date of E 5. Sociel Security Number Birthplece (State or Foreign Country) rs. lest birthday) 8. Date of Birth (Month, Dey, **Funeral** 10M 20 F Year) Days Min. March 10, 1938 New York 093-28-598 Usuel Residence of Decedent 60Yrs. Director with the Merylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yas 2 No Directo Saltimort Maryland L 10e. Street and Numbe 10f. Zip Coda 10g. Citizen of What Country? 14. Race - Amarican Indian, Bieck, White, etc. 21/36 Funeral 12000 Pages 1 and 2 should be filed within 72 hours efter deeth neat of Heelth and Mentel Hygiene.
smit: If item 27 is marked other than "naturel", or items 23.
ury or other fraumatic event, in Mendies Essenting mail 000 12. Wes Decedent Evar in U,S. Armed Forcas? Wes Dacedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 1 Never Married 2 Married 1 des 2 No If Yes, Give Yaer or Detes:/957-1□ Yes 2□No Baltimore, Maryland 21215-0020 Specify: Black Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind ot Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) gent ollection of Kerenye 17. Fether's Neme (First, Middla, Last) 18. Mother's Nema (First, Middla, Maiden Sumeme) Be Vilson Jaysura Taye Helen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Intorment's Name/Reletionship (Type, Print) Tarragon Road Reisterstown 2000 a4541a 11/0511 20a. Method of Disposition 20b. Plece of Disposition (Nema of cematery, crematory or other pleca) 20c. Location - City or Town, Stete February Important: If it any injury or o 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Removel trom State permit. Page Department of (rematory 24,1999) 4 ☐ Donetion 5 ☐ Other (Spacify) 22. Nama and Address of Facility Doug 1955 21. Signeture of Funeral Service Licenses Funeral Service 1701 McCulloh Street, Baltimore, MD 21217 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrast, shock, or heart feiture. List only one cause on each tine. Onset end Deeth **Physician** Immediate Ceuse (Final diseese or condition resulting in deeth) /Medical YRS CIRRHOSTS Examiner Due to (or es e consequence of): Examiner ettending physician end for use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Dua to (or as a consequence ot): Box 68760, Physician/Medical Dua to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. been signed by the should be deteched 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records, Completed by 24b. Were eutopsy tindings aveileble prior to completion of ceuse of deeth? 24e. Wes an eutopsy HYPERTENSTOR DISTASE 1 ☐ Yes 2 No 1 ☐ Yes 2 No or Attanding Physician: 25. Was cese reterred to medical exeminer? Be 26. Ptece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 No After this 28e. Dete of Injury (Month, Day Year) funerel 28b. Time of Injury 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Tyes 2 No 2 Accident after death Director: 6 ☐ Could not be determined To the Hospital or Attat within 24 hours after des To the Funeral Director completely filled in by th 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, and due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the ceuse(s) end menner stated. 29a. Certifier edicai (Check only one) 29b. Signature and title of certifian 29d. Date signed (Month, Dey, Year) 52360 X 30. Name and address of person who completed cause of death (Item 23a) (Type, Pript)

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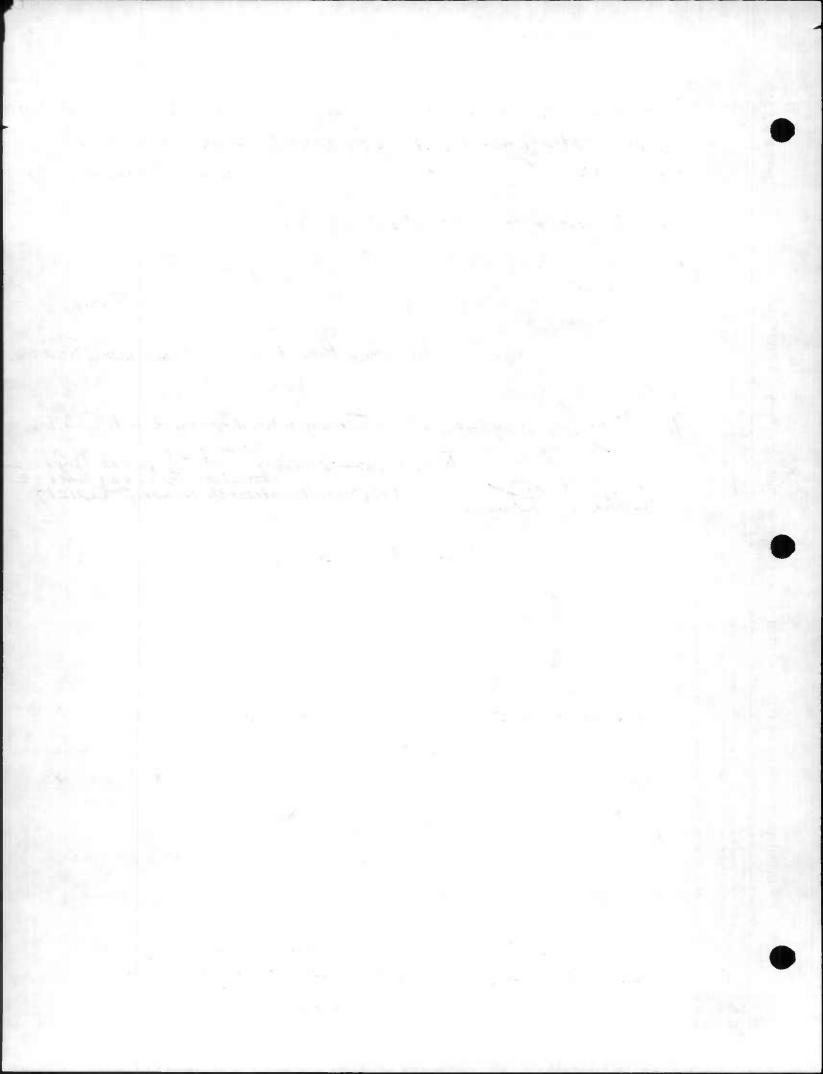
Registrar

DHMH 16 Rev 6/95

FEB 22

31. Dete fited (Month, Day, Year)

32. Registrer's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Data of Death 1. Decedent'a Nama (First, Middle, Last) 16:15 **Physician** KAISER HELEN MARIE FEBRUARY - /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BAYVIEW MEDICAL CENTER MARYLAND BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthpiaca (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🙀 F Yrs 219-66-6860 88 11-18-1910 Baltimore, Maryland Director Usual Residence of Deceden 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Mod pal Examinar must be notified at the Meryle 1 Yes 2 No Directo MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 103 S. Clinton Street 21224 USA Funeral death 12. Was Decedant Ever in U,S Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Ricen, atc.) 14. Race - American Indian. Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours efter Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturaly, or the any injury or other traumatic event, the Med call Examina. 1 Yes 2 No If Yes, Give Yaar or Datea: 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 1 No Specify: Specify: by 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Uauel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 3rd Homemaker In own home 18. Mother's Name (First, Middle, Maiden Sumema) 17. Father's Name (First, Middle, Last) Victoria Dockins James Lewinski 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) sister Mrs. Lillian Douglas 3410 E. Lombard Street Baltimore, Maryland 21224 20b. Place of Disposition (Name of cematary, crematory or other placa) 20c. Location - City or Town, Stete 20a. Method of Disposition 1X Buriai 2 ☐ Cramation 3 ☐ Ramovai from State 2/22/99 Baltimore, Maryland Meadowridge 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Joseph N. Zannino Jr. Funeral Hm. 263 S. Conkling St. Baltimore, Maryland 21224 23a. Part1. Enler the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) FIVE DAYS /Medical PNEUMONIA Examiner Due to (or as a consequence of) Examiner physician and s the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events rasulting in death) Last Due to (or es a consequenca of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by 1 Yes 2 No 3 Probably 4 VInknown OSTEOPOROSIS À 24b. Were autopsy findings available prior to complation of ceuse of death? 24a. Was an autopsy Completed has 1 ☐ Yes 2 ☐ No 1 Yes 2 12 No Hospital or Attending Physician:
 24 hours after deeth.
 Funeral Director: After this certific. funeral director. 25. Was case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of Certification: 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 1 Netural 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) To the To the To the 29d. Date signed (Month, Day, Year) 29c. Licansa number 29b. Signature and title of cartifier

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

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Danvence MD MEDICINE RESIDENT

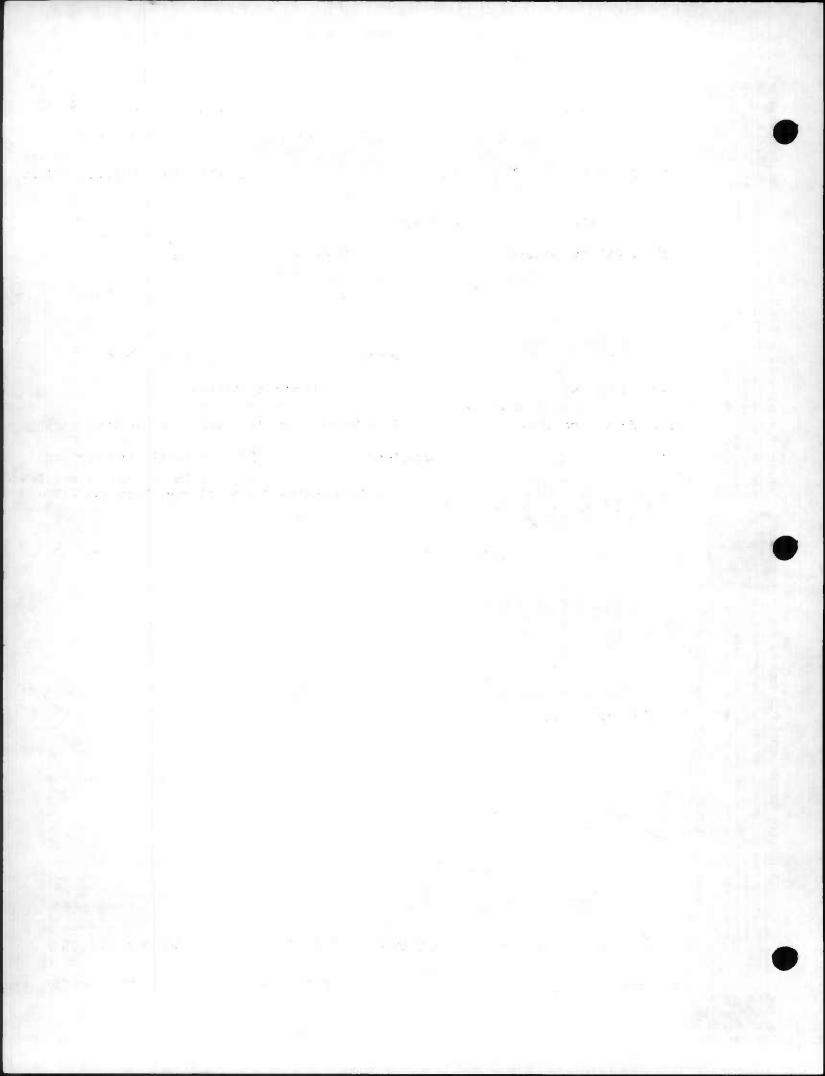
30. Nama and eddress of person who completed cause of death (Item 23a) (Type, Print)

B. Sparker

MARILYN LAWRENCE, MD. 600 NORTH WOLFE STREET, TOWER 110, BALTIMORE, MARYLAND, 21287.

05617.

FEBRUARY 19, 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Beldort nargaret 600 reb 4a Facility Nama (If not institution, giva street and number, 4b. City, Town, or Location of Death 4c. County of Death County General Hospital (o)umb/a Howard If Undar 1 Yaar If Undar 24 Hrs. 6. Date of Birth (Month, Dev. Y Sept. 12, 5. Social Security Number 6. Sex 7. Aga (In vrs. last birthday) 9. Birthplace (State or Foreign Country) New York Year) 1927 1 M 2 F Sept. 110-16-6380 71 Usual Rasidence of Decedant 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Howard Columbia 1 Yas 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6150 Foreland Garth, Apt.213 21045 USA 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Race - Amaricen Indian, Black, Whita, atc. 1 ☐ Yas 2 No 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yas 2X No Specify: If Yas, Give Yaar or Datas: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home 17 Fathar's Nama (First Middle Last) 18. Mothar's Nama (First, Middla, Maiden Surname) Thomas Zimber Margaret Kelly 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Dorothy B. Plantz (Daughter) 8968 Blue Pool, Columbia, MD 21045 20b. Place of Disposition (Name of camatery, crametory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 KIX ramation 3 ☐ Ramoval from Stata Baltimore Washington Crem 2/22/99 Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fureral Service Moense 22. Nama and Addrass of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road, Columbia, MD 21045 23a. Part1. Enter the disease, or complications that ceused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. Approximata Interval Between Onsat and Death Immediata Causa (Final Fibrillation diseasa or condition rasulting in daath) ardial myou Dua to (or as a consaquance of) Due to (or as a consequanca of): Pert II. Other algnificant conditions contributing to death but not resulting In the underlying ceusa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 Probably 4 Unknown 24b. Wara autopsy tindings available prior to 24a. Wes an autopsy performed? completion of ceuse of death? 1 ☐ Yes 2 ☐ No 25. Wes cesa rafarrad to medicel axaminar? 26. Placa of Death (Check only ona)

Physician /Medical Examiner

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for use as

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page 2 a certificate

funeral director,

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After

Hospital or Attending
 24 hours after death.
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Certification: To

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or Attending Physician: The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records.

Physician

/Medical

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10a. State

Director

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Hygiene.

Pages 1 and 2 should be fill ment of Heelin and Mental H lant: If Nem 27 is marked oth lary or other traumatic event

filed within 72 hours after

Baltimore, Maryland 21215-0020

Physician/Medical Examiner Sequantiatly list conditions, if any, laeding to immadiata causa. Entar Undarlying Ceuse (Diseasa or Injury thet initiated evants rasulting in death) Last Completed by

29e. Certifian

Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 178Yas 2 No 1 Dinpatiant 2 ER/Outpatient 3 DOA 27. Mannar of Death 28d. Describe how Injury occurred

28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 28c. Injury at Work? 1 Netural 2 Accident 5 Panding invastigation 1 Yas 2 No 6 Could not be 3 ☐ Suicida 28f. Location (Street and Number or Rural Routs Number, City or Town, Stete) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide

1 Sucertifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examinetion end/or invastigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) and manner stated.

(Check only one) 29b. Signature and title of certifie

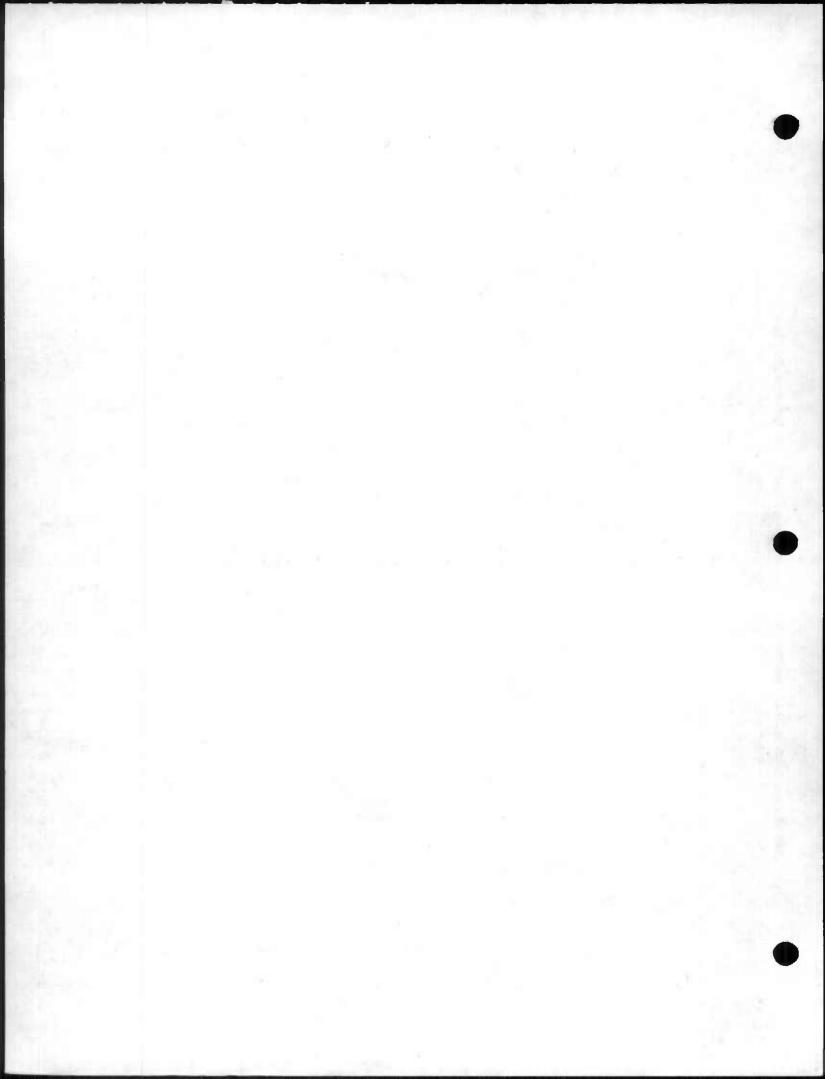
29c. Licanse number 29d. Dete signed (Month, Day, Year)

Name and address of person who completed cause of death (Itam 23a) (Type, Print)

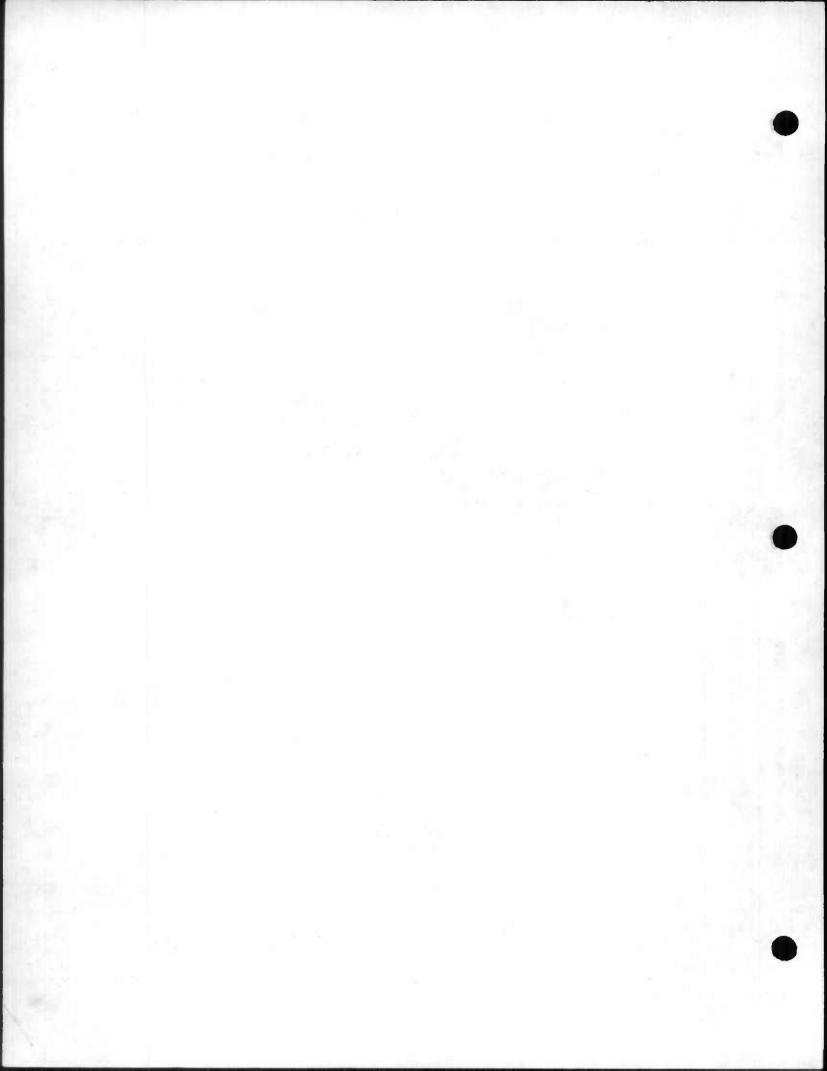
Columbia County General

State Registrar 31. Data filed (Month, Day, Year) FEB 2

32. Registrar's Signatura



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Physician	1. Decedent's Nam		nst)							2. Dete of Do	eath Day	Year	3. Time of Death	
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Funeral Director	5. Social Security N 219–20–92	C124-1-1	Sex 1□ M XX F		n yrs. last birtho	N/ N	Under 1 Year Ionths Days	If Under Hours		8. Date of Bi (Month, D	irth ey, Year) 6, 1928	-	ace (State or Foreign try)	
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21215-0020 ad within 72 hours after ser than "natural", or he t, the Medical Examina	(Spec	15. Decedent's E city only highest gr andary (0-12)	ade completed	f) (1-4or 5+)	(6	ive kin	t's Usuel Occup d of work done NOT use retired	during mos	it of worki	ng	16b. Kind of B	Business/Ind	ustry	
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altimore, mil. Pages 1 se partment of Hea portunit if Heam y Highary or other ca.		position Cremetion 3 [5 Other (Speci			20b. Place of Dicemetery, Holy C	cremet	ory or other plea		uary	Date 24, 19	20c. Location 999 Ball			
Baiti permit. Departm Imports any inju	21. Spentum of Funeral Service Liversee Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Mary shock, or heart failure. List only one cause of second s													
Physician /Medical Examiner	Immediate Cause disease or condition resulting in death)	(Final		eta	e death. Do not	ti	C	1			m Ce Y		Approximete Intervel Between Onset and Death	
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DIVISION C ne eter death. et Director: Afer t led in by the funera Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not to	20e. Mac	ce of Injury ding, etc. (S	- At home, ferm Specify)	, street,	, fectory, office		1		(Street end Num own, Stete)	ber or Rure	Route Number,	
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10	30. Name and addr	ess of person who	completed cau	use of death	(Item 23a) (Ty		1	107	1105	Zita	I cen	100	MD21225	
State Registrar	31. Date filed (Mon		32.	Registrar's	Signeture	4	10015	7		CV	مررس	17011	7,000	
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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death February 15,1999 Year Physician Marie Louise Kline 1:16 A.M. /Medical 4a Facility Nama (If not institution, give street and number)
4513 Woodlea Avenue 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore N/A If Under 24 Hrs. 5. Social Security Number 216-28-7916 If Under 1 Year 8. Data of Birth 2(Month, Pays Year) 6. Sax 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) Funeral Days 89 Months Hours 1 M 2 XF Director Maryland Usual Residence of Decedent 10e State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD 1 Tas 2 No N/A Baltimore Director "natural", or hame 23a or 25a-f idical Examiner must be notifis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4513 Woolea Avenue 21206 U.S.A. Funeral 14. Race - Amarican Indian, 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiens. Important: if Item 27 is marked other than "natural", or Item and Highly or other traumatic event, the Medical Eventhan ands. Black, Whita, atc. Specify: White 1 ☐ Yes 2 ☑ No If Yas, Giva Year or Detes: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 Yas 2 No Specify: 3 d Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) George Dorbert Mary Seifert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Coda) James G. Kline 5010 Oaklyn Avenue Baltimore, Maryland 21206 20b. Place of Disposition (Nama of cemetery crematory or other place)
Sacret Heart of Jesus 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from Stata 2/18/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) John C. Miller Inc. 21. Signature of Funeral 5 22. Nama and Address of Facility 6415 Belair road Baltimore, Maryland 21206 The distance, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and the control of the control Approximete Interval Between Onsat and Death Physician /Medical tmmediata Cause (Final disease or condition resulting in death) UROSEPSIS Examiner Examiner CEREBROVASCULAR ACCIDENTS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical Dua to (or as a consequence of): signed by the aid do be detached for 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Ware autopsy findings availabla prior to completion of cause of daath? Completed 24a. Was an autopsy performed? 1□ Yes 2□ No 1 Yas 2 No 25. Was case referred to medical axaminer? B 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Homa 5 ☐ Residence 6 ☐ Othar (Specify) 1 Yes 2 No Certification: To this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? Affair or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as ststed. Medical 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and mannar stated. 29c. License number 29d. Data signed (Month, Day, Year) 045568 30. Name and address of person who completed causa of daath (Item 23a) (Type, Print) Belain 9524 BRADFORD L. EBRIGHT

Registrar

State

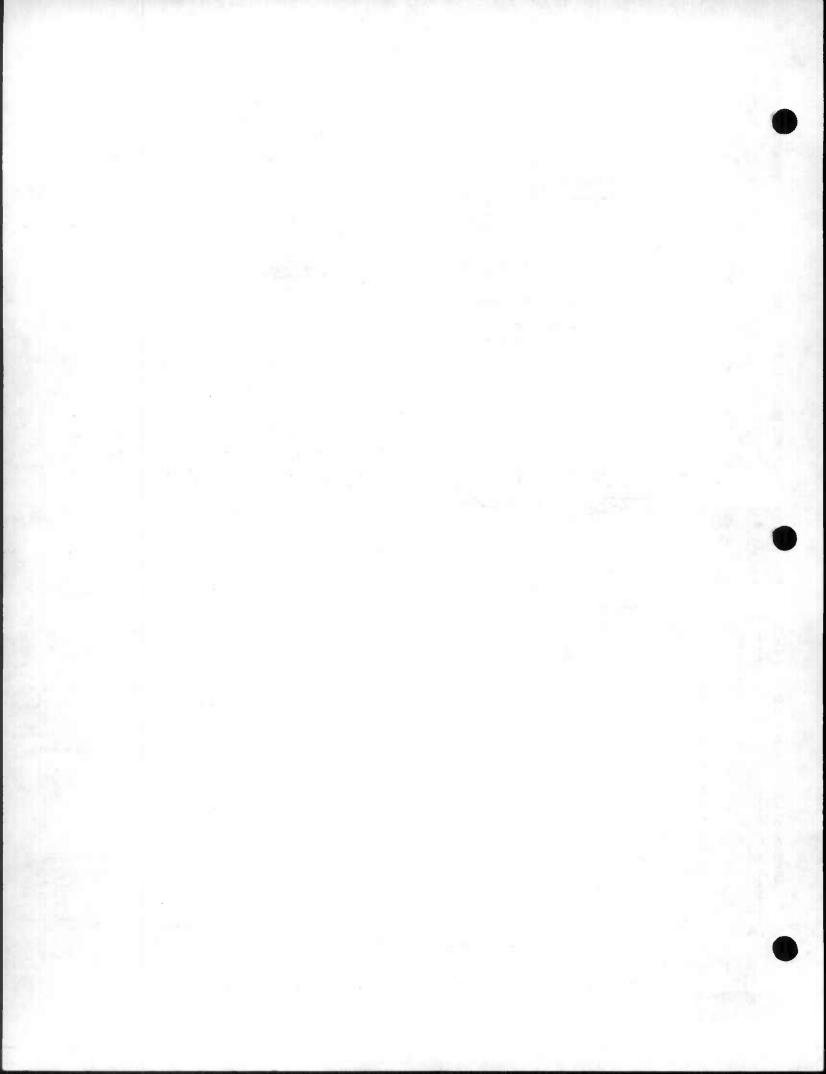
31. Data filed (Month, Day, Year)

FEB 2 2 1999

ORIGINAL

32. Registrar's Signatura

Geneva



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Months

If Under 1 Year

Days

HOSPILAI

7. Age (In yrs. lest birthdey)

65

3. Time of Deeth

3:54 P.M.

Birthplace (Stete or Foreign Country)

4c. County of Deeth

BAITIMORE

4b. City, Town, or Location of Deeth Rosedale

If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer)

June 13 1933

SQUARE DR. BAITIMURE, MARY And 21237

		ļ	1. December Name (First Middle Louis	-41
	Physici		1. Decedent's Neme (First, Middle, La Emma L.	Kral
	/Medic Examir		4a Facility Name (If not institution, giv	RE HAS
	Funeral Director		219-28-5079	ex 7. Ag
	p		Usual Residence of Decedent 10e. Stete 10b. County	
	Maryle Ff show	tor	MD Balti	more
	h with the 23a or 28a	ai Direc	10e. Street end Number 7811 Meath Rd	
020	a 1 and 2 should be filed within 72 hours efter death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28a-f show other traumatic event, the Madical Examinatment be notified.	Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Yeer or Dates:
5-0	72 ho	sted	15. Decedent's Ed (Specify only highest gra	
2121	within iene. then	omple	Elementery/Secondery (0-12)	College (1-4or
land	1 end 2 should be filed with Health and Mental Hygiene. em 27 Is marked other than ither traumatic event, man	To Be C	17. Fether's Neme (First, Middle, Last, George R. Bat	tersby
Mary	id 2 shou lth and M 27 is mark traumati	-	19a. Informent's Name/Reletionship (
Baltimore, Maryland 21215-0020	Pages ant of H nt: If the ry or on		20a. Method of Disposition	Removel from State
Balti	permit. Pa Departmen important: any injury stics.		21. Signature of Funeral Service Licer	et Corn
	Physician		23e. Pert1. Enter the disself e, or com shock, or heert failt List only	plicetions that cause one cause on each II
٦	/Medical Examiner		immediate Ceuse (Finel disease or condition resulting in deeth)	· Blada
	executed n end iel-transit	n/Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying	b
ox 68760	certificate be executed nding physicien end use es the buriel-transit	Medical I	Ceuse (Disease or injury thet Initiated events resulting in deeth) Last	c
ŏ	ndir use	5		d

Physici

Completed by

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Certification:

Medical

DR. Pedro Amador

31. Dete filed (Month, Dey, Year) FEB 2 0 199

9000 FRANKlin

32. Registrer's Signeture

mmA

I Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No dP. Baltimore Dundalk Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7811 Meath Rd 21222 USA 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? farital Status Bleck, White, etc. 1 ☐ Yes 2 No Never Married 2 Married 1 Yes 2 No Specify: Specify: White ☑ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home ether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) George R. Battersby Catherine A. Busse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informent's Name/Reletionship (Type, Print) Baltimore, MD 21222 Margaret Roberts /daughter 17 Midship Rd 20b. Place of Disposition (Name of cemetery, cremetory or other place) Cem. Method of Disposition Date 20c. Locetion - City or Town, Stete Feb 22 Burial 2 □ Cremetion 3 □ Removel from State □ Donetion 5 □ Other (Specify) Sacred Heart of Jesus 1999 Baltimore, MD Signature of Funeral Service Licensee 22. Name end Address of Facility
Connelly Funeral Home of Dundalk 7110 Sollers Point Rd onne o not enter the mode of dying, such as cerdiec or respiratory errest, Approximete Interval Between Onset end Deeth edlate Ceuse (Fine 2 Mon Ths Bladder ese or condition Iting in deeth) ANCER Due to (or es e consequence of) uentially list conditions, y, leeding to Immediale se. Enter Underlying se (Disease or injury Initiated events Iting in deeth) Last Due to (or es e consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CANCER CORONARY ARTERY 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24e. Wes en eutopsy RESPIRAJORY DISTRESS 1 Yes 2 No Hyper Ten Sign
25. Was cese referred to medical exeminer?
1 yes 20 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Naturel 2 ☐ Accident Injury 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) end menner es steted.

[2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Dete signed (Month, Day, Year) 29c. License number 186478 and address who completed cause of death (Item 23a) (Type, Print)

W. State Registrar

Division of Vital Records, P.O.

certificate

this funeral

After

efter death.

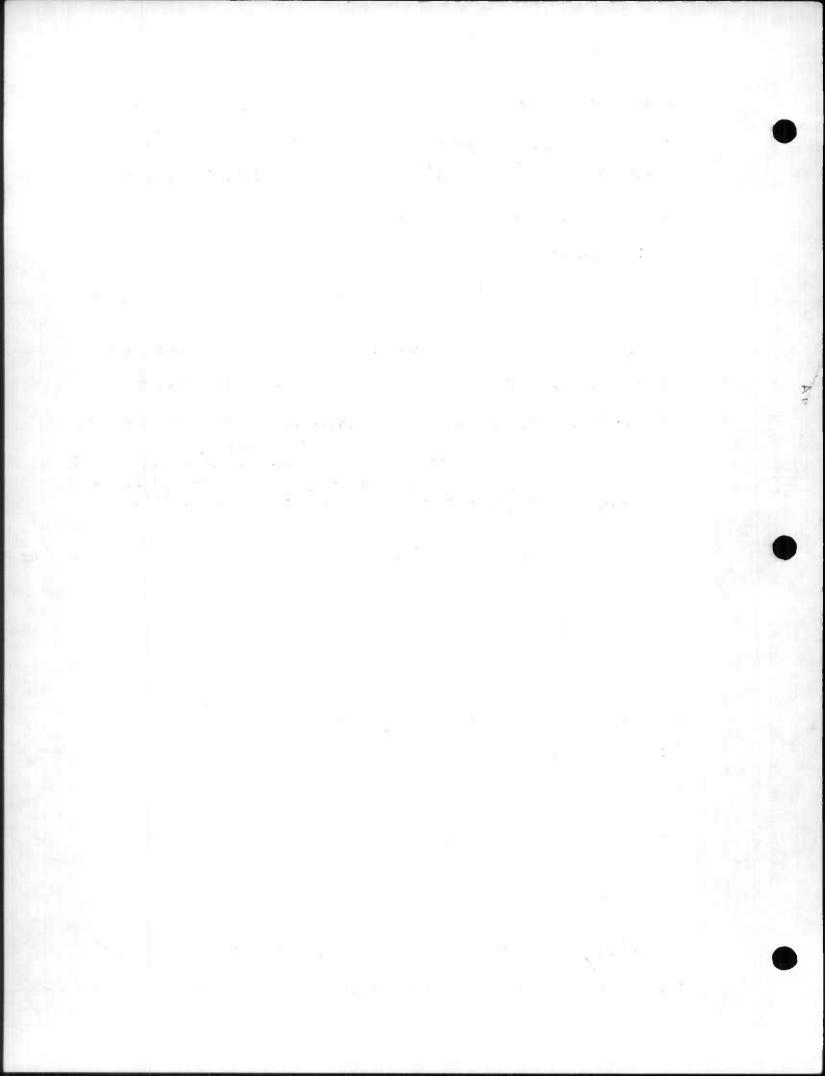
24 hours e Funeral (

within 2 To the

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director

Hospital or Attending Physician:



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 20 1999 5:40 AM Margaret G. Lucas 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Reisterstown Baltimore 117 First Ave If Under 24 Hrs. Apy 11 Day 9 1901 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Months Days Hours Min 1 M A F GETTANY 97 Yrs. 216-07-9572 Usual Residence of Decedent 10d. inside City Limits 10a. State 10c. City, Town or Location Reisterstown Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 117 First Ave 21136 USA 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) 8th Grade College (1-4or 5+) Local Union Seamtress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth France Johann Goldberg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Reisterstown, Md. 21136 117 First Ave. Margaret R. Sullivan 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore National Cem 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/23/99 Baltimore, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service-Licensee 22. Name end Address of Facility 11824 Reisterstown Rd. Eline Funeral Home Reisterstown, MD. 21136 23a. P. rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death immediate Cause (Final disease or condition resulting in death) weeks DEHYDRATION Due to (or as a consequence of) DYSPHASIA Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) DEMENTA Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 20 No 1 Yes VO No 1 Yes 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home SP Aesidence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending investigation 1 TYes 2 TNo 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

The law requires that the death certificate be executed physician and s the bunal-frent Division of Vital Records, P.O. Box 68760, SE ettending , 980 ed by the e signed b been sig cartificate has b page Physician: this Aftar this funaral o or Attending To the Hospital or Attending within 24 hours efter death.
To the Funeral Director: Afte compietaly filled in by the fun.

Physician

/Medical

Examiner

Director

Funeral

by

Completed

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Director

with the Marylend

pennit. Pages 1 end 2 should be filed within 72 hours after death with the Marylen Department of Haaith end Mental Hygiena. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any in ury or other traumatic event, the Medical Examinat must be not the

Physician /Medical

Examiner

Physician/Medical Examine

by

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Certification:

edicai

29a. Certifier (Check only one)

29b. Signature and title of certifier

selle

State Registra

DHMH 16 Rev 6/95

NOELLA MISQUITA 31. Date filed (Month, Day, Year) FEB 2 2 1999

MO

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) BENSON 31, 21 BENS 32. Registrar's Signature Denewa

230, BALTIMORE,

MD21227

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

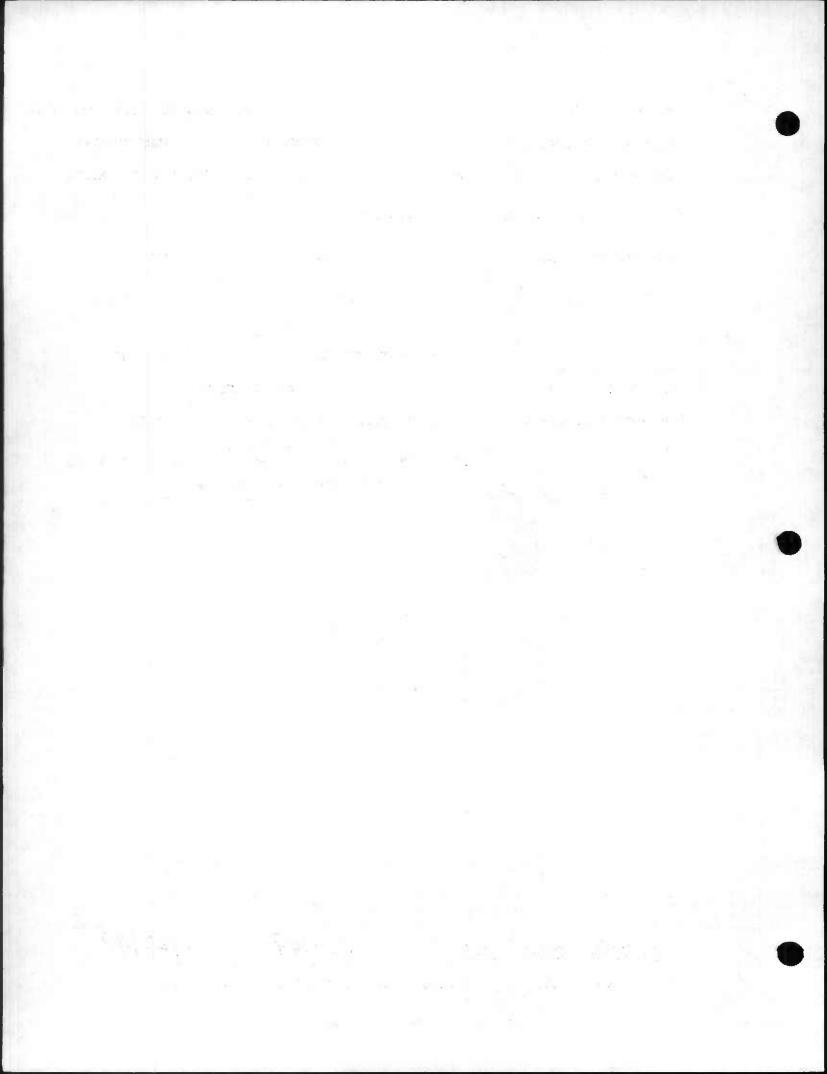
| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.

29c. License number

AND THE RESERVE AND THE RESERV are residented affected from the application on the field Management of the Toronto.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes O

			Decedent's Name (First, Middle	20 16			rtificate of	Death		Reg. No.	UU	3. Time of Death		
	Physic /Medi	ical	Henry A. Lamb						Februa	ry 20,	Year 1999	3:15 P.M		
A	Exami	ner	4a. Facility Name (If not institution,		ber)			4b. City, Town, or	Location of Deet	4c. Count	y of Deeth			
Н			1435 Odenton F 5. Social Security Number		Ann do um	land birdh da. A	If Under 1 Year	ODENTON If Under 24 Hrs.			E ARUN			
	Funeral Director		409-38-7683 Usual Residence of Decedent	12XM 2□ F				Hours Min. 8. Date of E (Month, I)		y, Yeer)	9. Birthple Countr TENNE	nce (Stete or Foreign y) SSEE		
	Marylend f show	or	10a. State 10b. County	ARUNDEL	10c. C	ity, Town or Lo	ocation NTON				10	d. Inside City Limits		
	h the h	frect	10e. Street and Number				10f. Zip Code			10g. Citizen of	Whet Countr			
Maryland 21215-0020	th wil	aiD	1435 ODENTON R	OAD			2	1113		UNITE	D STAT	ES		
	72 hours after death with the Maryland "natural", or frame 29a or 28a-f show of cal Examinat must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 ☑ Divorcad	12. Was Deceded Armed Force of 1 Types 2 If Yes, Give Year or Date	es? 19 □No 19	50-	Was Decedent of f Yes, specify Cut 1 ☐ Yes 2 No	Hispenic Origin? (S pan, Mexican, Puerl Specify:	pecify Yes or No o Ricen, etc.)		ce - America ck, White, et y: WHI	tc.		
	within ene. than	Completed	15. Decedent' (Specify only highest Elementery/Secondary (0-12)	s Education grade completed) College (1-4	Sor 5+)	(Give life. L	dent's Usual Occu kind of work done DO NOT use retire	during most of wor ad)	king	16b. Kind of B	stry			
B	be filed itel Hygi d other event,	BeC	17. Father's Name (First, Middle, L	ast)		TENTINI	DIVANCE II	7	MAINTENANCE me (First, Middle, Maiden Sumeme)					
ylaı	0 to 10 to	ToB	WILLIAM HENRY	LAMB				NANNIE	WILLHOI	Г				
Mar	12 sh h and r is m raum		19a. Informant's Name/Relationsh MARY MENSCH/DAU				og Address (Stree		ENTON .	er, City or Town, Stete, Zip Code) MD 21113				
Baltimore,	permit. Pages 1 and 3 Depertment of Health Important: if item 27 I any injury or other tr. once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion			Place of Dispo	sition /Neme of	FEBRUA	Date	20c. Location		n, State		
E	tant:		4 Donation 5 □ Other (Sp.	ecify)		NATION	MEM. PK	. 19	99	LAUREL	, MARY	LAND		
Bai	Deper Impor any in		21. Signature of Funeral Service L	censee (KII		ess of Facility DDICK FUN HWY. S.E.						
,09/90,	Medicale pe executed a physician and as the buriel-transit	ledical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	eA12	Due to (d	er's Disporas a consequence as a consequ	uence of):							
gox	that the death cert ed by the ettendin detached for use	Physician/N		d										
	the e	ysic	Part II. Other significant condition	a contributing to deet	h but not res	ulting In the un	derlying cause gi	ven in Part I.	23b. Did	lobacco use co	ntribute to t	he cause of death		
7.7.	ned by e detac	by Ph							1 🗆	Yes 217 No	3 Proba	bly 4 Unknow		
Division of Vital Records,	The law requires that the death cer ate hes been signed by the ettendin pege 2 should be detached for use	Completed t							24a. Was perfo	en autopsy rmed?	avail	e autopsy findings able prior to pletion of cause eth?		
	The safe peg	Co							10	res 2 No	10	Yes 2□ No		
=	clan Sertifi ector	Be	25. Was case referred to medicel examiner?	Hospital			100	26. Place of Dea	th (Check only o	ne)				
0 00	To the Hospital or Attending Physician: The is within 24 burns either death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ation: To	1 Yes 2 X No 27. Manner of Deeth 1 X Natural 5 Pending 2 Accident Investiga			28b. Time of Injury	28c. Inju		ome 5 X Reside 1	dence 6 Oth				
בואוס	s efter de N Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could no determin	ed 286. Piece of	Injury - At he etc. (Specif	28f. Location (Street end Number or Rural Route N City or Town, Stete)				Route Number,				
	• Hospit • Funeral • Funeral • Hotely fill	edicai	29e. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the be taminer: On the basis and manner	s of examina	wledge, deeth tion and/or inv	occurred at the tile estigetion, in my c	me, date end place opinion, death occur	end due to the red at the time,	cause(s) and ma date and place,	anner es stat end due to ti	ed. ne cause(s)		
	To the To the comp	Me	29b. Signeture and title of certifier	Super S 11	4.0	O.A.	29c. Licens	H149		29d. Date signe 2/22	d (Month, De	ey, Year)		
,	5		30. Name and address of persin wi Dorothy Snow, M					timore	da nylana	21201	1 ' '			
	Sta	te	31. Date filed (Month, Day, Year)	32. Regi	strar's Signa		cet, bdl	cimore, i	naryiano	21201				
	Registr		FEB 2 2 1	999	neva	19	/							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. I. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death - Month eath February 18 3:15 AM 1am 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Ba Hmore topluns Ohns Hospita If Undar 1 Year | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) APR 28 19 Birthpleca (Stata or Foraign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) Days Months Hours 10XM 2□ F 70 Yrs. 245-30-3326 1928NORTH CAROLINA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Nas 2 No MARYLAND N/A BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10n. Citizen of What Country? 716 WATER TOWER 21212 U.S.A. 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puerto Rican, atc.) 11 Marital Status 1 Nevar Married 2 Merried BLACK 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8th grade College (1-4or 5+) LABORER STEEL COMPANY 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) JOHN A LEATH HATTIE G. LEATH 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 710 Johns Forest Trail, Burlington, NC 27217 Clastene Leath/Sister 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 1 Perial 2 Cramation 3 Removal from State Data 20c. Location - City or Town, Stata UNION CHAPEL CHURCH 12-23 4 ☐ Donation 5 ☐ Other (Specify) BURLINGTON, NC 21. Signature & Fu 22 Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME course 1206 W NORTH AVENUE PA 23a. Part Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onsat and Daath immediate Causa (Final diseasa or condition resulting in death) lu ear tmonth ple Due to (or es a consequance of) Dua to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of causa of death? 24a. Wes en eutopsy performed?

Physician /Medical Examiner

attending physician and for use as the burial-transit

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certificate

Box 68760

Records, P.O.

Division of Vital

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examinar must be notified at

with the Maryland

death

filed within 72 hours after

permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "na any injury or other traumatic event, the Media. Page.

Baltimore, Maryland 21215-0020

Examiner Physician/Medical signed by to d be detach þ Completed To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: Affer this certifica completely filled in by the funeral director, to Be 2 Certification:

edical

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Diseese or injury that initiated events rasulting in death) Last

25. Was casa rafarred to medical examinar?

1 Yas 25 No

27. Manner of Death

1 Natural
2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 28b. Time of

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Dascribe how injury occurred

1 ☐ Yas 2 No

28c. Injury at Work? 1 □ Yas 2 □ No 28f. Location (Street and Number or Rural Routa Number, City or Town, State)

MD

Certifying Physician: To the best of my knowledge, deeth occurred at tha time, data end place, end dua to the cause(s) end menner es stated.

Medical Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the ceuse(s) and manner steted.

29b. Signature and titla of certifiar kuma

5 Pending

invastigation 6 Could not be

1 ☐ Yas 2 ☐ No

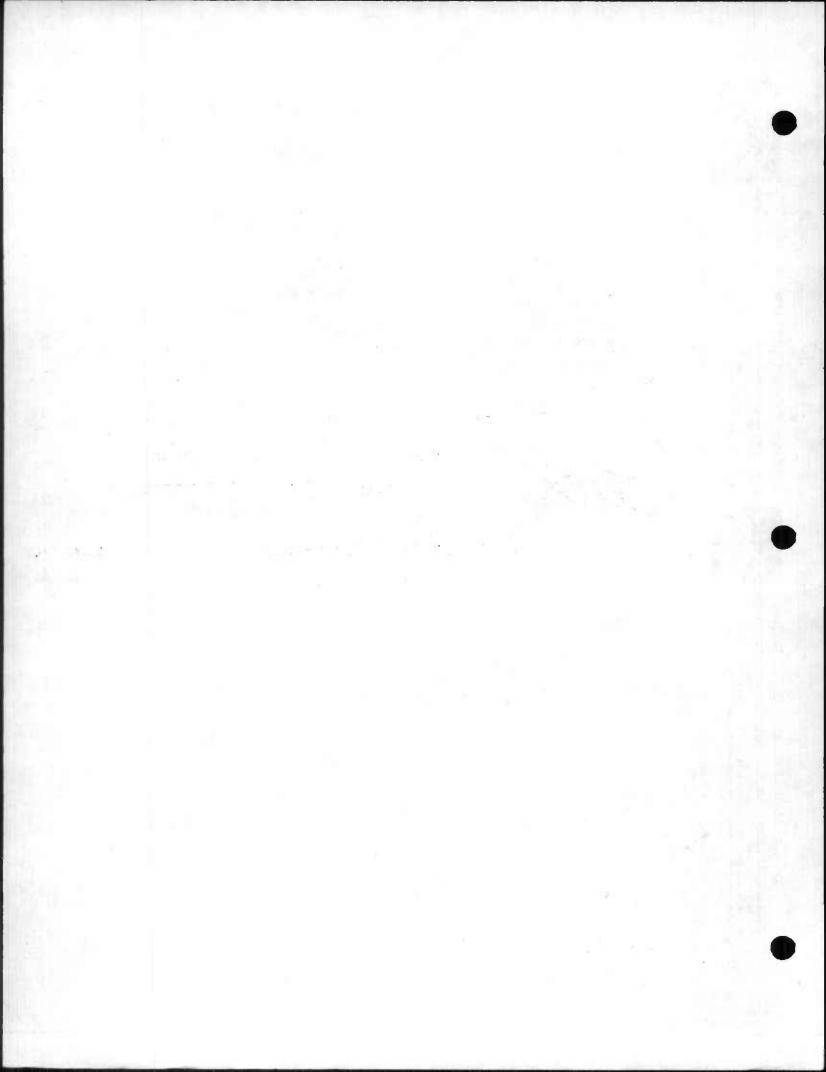
30. Nama and address of person who completed ceusa of death (Itam 23a) (Type, Print)

Wolfe Street

31. Data filed (Month, Day, Year)

32. Ragistrar's Signatura

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

m		Decedent's Neme (First, Mide	Certificate of Death						2. Data of Death Month Dev Year				
	sician ledical	Jo	seph Willi	am Lucc				Feb. 20, 1999 163			1630		
100	aminer	4a Facility Nama (If not institution, give street and number)					4b. City, Town, or	Location of Deeth	4c. County	of Death			
				3D		If Under 1 Year	Owings M:						
Fune Direc		5. Social Security Number 217-07-7073 Usuat Rasidance of Decedant	6. Sex 1 2 M 2 □ F	Sax 12 M 2 F 7. Aga (In yrs. last birthday) If Under 1 Y Months D				. (Month, Day	Year) 4,1917	9. Birthplac Country Penns	e (State or Foreign sylvania		
yland		10a. Stata 10b. Count	у	10c. Ci	ty, Town or Lo	cation				10d.	. Inside City Limits		
Mor Meri	ctor	Md. Balti					1 ☐ Yas 2 No						
ith with th	rai Director	10e. Street and Number 35 Strawh	nat Rd. Ap	t. 3D		10f. Zip Coda 2	1117		10g. Citizen of V	S.A.	7		
OUZU hours after death with the Menjand ural', or items 23a or 28=1 show	by Funeral	11. Maritel Stetus 1 Nevar Married 2 Ma 3 XWidowed 4 Divorce	rried 1 Yas	Decedent Evar in U,S. ad Forcas? If Yas, specify Cuban, If Yas 2 No s, Giva or Datas:				Specify Yas or No- to Rican, atc.)	14. Rac Blac Specify	Race - Amarican Indien, Black, Whita, atc.			
within 72 one. Than "nat	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	15. Decedent's Education (Specify only highast grada completed) (Secondary (0-12) Collega (1-4or		(Giva kind lifa. DO		ant's Usual Occupation kind of work dona during most of wo O NOT usa retired)			Businass/Industry			
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Vian Suld be Mental	ToB	William	William Luco										
2 should and Men is marke		19a. Informant's Name/Relation			1000		t and Number or R				ode)		
E = N N		Edith C. Spar	igler Ste			Brunk :	Rd., Reis	Data	, Md. 2		State		
Pages ent of rt: If h	5	1 M Burial 2 ☐ Cramation 4 ☐ Donation 5 ☐ Other (State	cemetary, cram	natory or other pla							
permit. Pages 1 at Department of Hee Important: if item:	ODCE.	21. Signetura of Funaral Sarvice Licensea 22. Nama and Addrass of Facility 23. Part 1. Entar the disaasa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or raspiratory errest.									1117		
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death certificate be executed attending physician and of or use as the buriel-transit	ledical	Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disass or Injury that initiated evants rasulting in death) Last	c	Due to (d	or as e consequ	uance of):							
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or Attending Physician: The lew requires the after death. Director: After this certificate has been signed in the funeral director, page 2 should be a	Completed by								an eutopsy med?	availe	autopsy findings able prior to pletion of cause eth?		
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lan: artifica ctor.	Be	25. Was casa rafarred to medic examinar?	al				26. Place of De	ath (Check only o	na)				
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tal or Att	Certifi	4 Homicida deter	mined 28a. Ptace	eet, factory, office		28f. Location (S City or Tow	street and Numb m, Stata)	oer or Rural F	iouta Number,				
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To the To the	¥	29b. Signature and I la of certifi	ar			29c. Licer	sa number	1	29d. Data signe	d (Month, Da	y, Year)		
1		30. Name end eddress of person	D Atte	nding	n 23a) (Tune I	18-6			Feb:				
V	u	01 1.5 1.1.	+e110, M	-	3ch Tr	auma C	TR. 229	Greene	Balt.	Md 21	20/		

DHMH 16 Rev 6/95

Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended#23apt1 perPHYG768 2/22/99 EW 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Maximiliam Lackl
40 Facility Name (If not institution, give street and number) 1999 4b. City, Town, or Location of Death 4c. County of Death Church Hospital Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 13, 1921 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Days 1 € M 2 □ F Hours Months Germany 215-18-5686 77 Usual Residence of Decedent 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Harford Edgewood Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 831 Angel Valley Court 21040 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑NYes 2 ☐ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: 3 XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Security Officer Court House 7th Grade 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Neumaier Ludwig Lackl Regina 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 831 Angel Valley Ct., Edgewood, MD 21040 Larry George Lackl. Sr. (son) 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removel from State Holly Hill Mem'l Gardens 2/11/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Schimunek Funeral Home, Inc. 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, 21236 23a. Pert1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tntervat Between Onset end Death SEPTICEMIA Immediete Cause (Final disease or condition resulting In death) 2 Weeks Due to (or as a consequence of) DECUBITI (SACRAL ULCERS) 1 Year Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): STROKE 1 Year Due to (or as a consequence of):

Physician /Medical Examiner

Pages 1 an

Baltimore,

other

5 Department of traportant: If any injury or pace.

Physician

/Medical

Director

Funeral

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Completed

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Director

Examiner physician and the bunal-transit requires that the death certificate be executed Physician/Medical tor use as Be Completed by or Attending Physician: edical Certification: To this death. To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al completely filled in by the fu

Division of Vital Records, P.O. Box 68760,

Part tt. Other significant conditions con	tribution to double but not you	sulting in the condensate	sa sauga siran in Dari I	225	Did tohoone was so	entribute to the cause of death
	(Cers	suiting in the underlying	ng cause gwen in Part I.	230.	1 Yes 2 No	3 □ Probably 4 □ Unknow
					Was an autopsy performed? 1 ☐ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical			26. Place of De		/ 1	12.00 -47.0
examiner? 1 ☐ Yes 2 ☑ No	ospitel: 1 Inpatient 2	ER/Outpatient 3	Other		Residence 6 □Oth	ner (Specify)
27. Manner of Deeth 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Dey Year)	28b. Time of injury	28c. Injury at Work? 1 Yes 2 No	28d. Desc	cribe how injury occur	rred
3 Suicide 6 Could not be determined	28e. Placa of Injury - At h building, etc. (Speci		story, office		tion (Street and Numb or Town, State)	ber or Rural Route Number,
			red at the time, date and plac tion, in my opinion, death occ			
29b. Signature end title of certifier			29c. License number		29d. Date signe	d (Month, Day, Year)

1990

21231

100 N. Broadway Baltimore. MD

State Registrar nd address of person who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

FEB

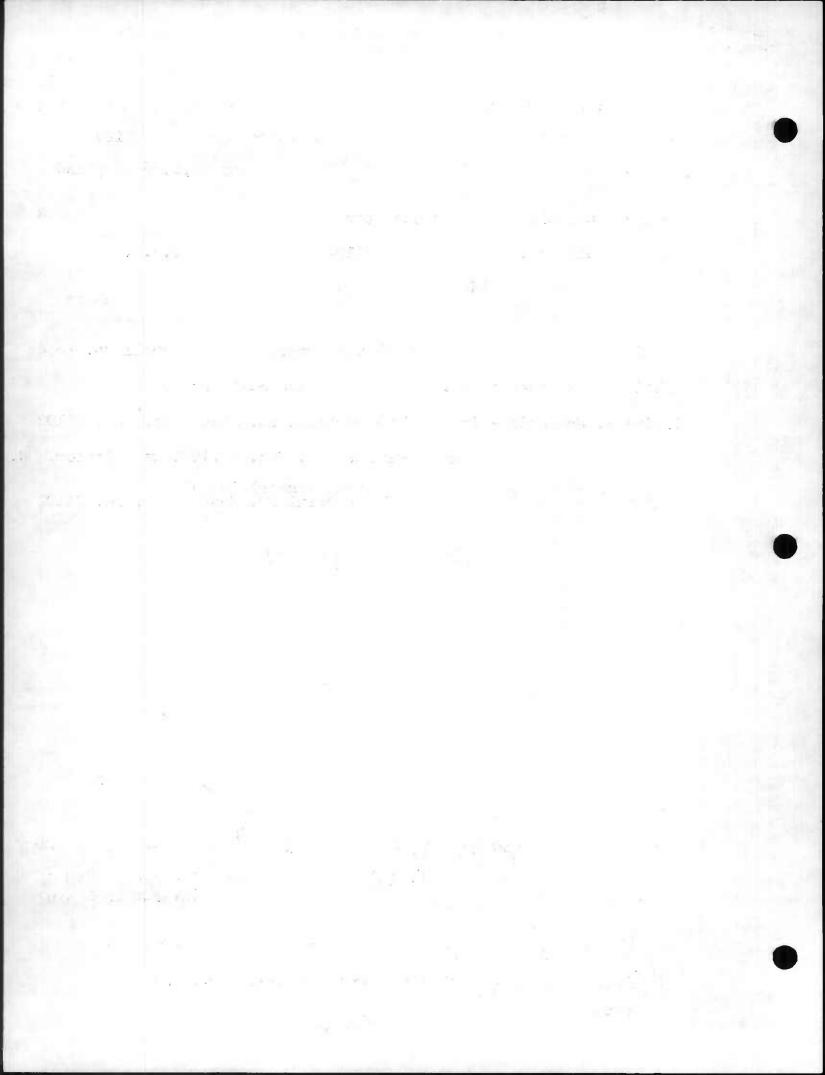
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1999

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				Departm Certific				Reg. No. 9	05	112	
Physician		1. Decedent's Name (First, Middle, Last)						nath Dey	Year 1999	3. Time of Deeth	
/Medical	Michael Lee McKenzie 4a Facility Nama (If not Institution, give street and number) 4b. City. Town, o						FEBRUA	1947 PM			
Examiner	4a Facility Nama (If not Institution, g UNIVERSITY HOSPI				ORE CITY	4c. Count	y of Death City				
Funeral Director	217-08-4546	Sex. 7. Ag	ge (in yrs. last 22	Yrs. If U	ndar 1 Yaar ths Deys		fin. 8. Date of Bi	", Year 976	9. Birthpla Countr Mary	ce (Stete or Foreign	
1	Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location								100	d. Inside City Limits	
23s or 28s-f shows sust be neathed at rail Director	Maryland Carroll Manchester							1 🗆 Yes 2 🗹			
or 28a-f s be notities Director	10e. Street end Number			. Zip Code			10g. Citizen of Whet Country?				
23a o	2902 Michelle	Rd.		2	21102			U.S.	Α.		
Staminer or theme	11. Marital Status 11. Never Married 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced	12. Was Dacedant Armed Forces 1 Yes 2 If Yas, Give Yeer or Detes:	Specify: Sp						ick, Whita, et	e - American Indian, k, Whita, etc.	
Instural'.	15. Decedent's (Specify only highest of	Education	cetion 16e. Decedent's Usua (Give kind of won			pation during most of	working	16b. Kind of E	Businass/Indu	stry	
ygiene. or than "naturi it, it a Mexical Completed	Elementary/Secondary (0-12)		College (1-4gr 5+)			d of work done during most of working NOT use retired) 10USE Worker			11 Co	. Foods	
	17. Fether's Neme (First, Middle, La	et)		warenc	use					· roods	
2 0	William Paul						Neme (First, Middle, Meiden Surname) Mary Arnone				
market matic	19e. Informent's Neme/Reletionship			19b. Mailing Add	iress (Stree		Rurel Route Numb		, Stete, Zip C	Code)	
27 is m er traum	William P. McK	enzie - f	ather	2902	Mich	elle R	d. Manchester, Md. 21102				
retto r	20e. Method of Disposition		cema	e of Disposition atery, crametory	or other ple		Dete	20c. Location - City or Town, Stata			
ortant: If injury or e.	1		Mead	lowbrar	ich C	em. Fe	b. 24,1	999 We	stmin	ster, M	
Important: I any injury o pnce.	21. Signeture of Funeral Service Lic	22. Name end Address of Fecility Eckhardt Funeral Chapel 3296 Charmil Dr. Manchester. Md. 2110									
fedical aminer	Immediate Ceuse (Final diseese or condition resulting in death)	θ	Due to (or es	s e consequence		ure	2				
n and tal-transit Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	0.	Due to (or as	a consequence	ot):				i		
the but	Cause (Disease or injury that initiated events resulting in death) Last	0.	Due to (or as	a consequence	of):						
r use as	W	d									
the att	Part II. Other significant conditions	contributing to death b	out not resultin	g in the underly	ing cause g	iven in Part I.	23b. Did	tobacco use o	ontribute to t	the cause of death	
the detact by Phy					1	170	10	Yes 2010	3 Probe	abity 4 ☐ Unknow	
should should leted								s an autopsy ormed?	oom	e autopsy findings lable prior to plation of cause sath?	
page 2							130	Yes 2□No	100	Yes 2 No	
ractor, pa	25. Was case referred to medical examiner?					26. Place of	Death (Check only	ane)			
din o	esaminer? A⊠ Yes 2□ No	Hospital: 1XXnpati		/Outpatient 3E	2 COOM	Address of the Control of the Contro	The second second second second	Home 5 ☐ Residence 6 ☐ Other (Specify)			
funeral flon:	27. Mariner of Death 1 □Natural 5 □ Pending	Month, gi	(Month, Day Year) Injury Work?					Describe how injury occurred			
in by the	3 Suicide 6 Could not determine	be 28e Place of In	iury - At home c. (Specify)	tarm, street, to		- 1	281. Location	(Street and Num ym, State)	ber or Rural	Route Number,	
pietely filled edical C	29a. Certifying 1 Certifying I	Physician: To the best aminer: On the basis of and manner st	of examination	dge, death occu and/or investig	rred at the tation, in my	ime, date and p opinion, death o	ace, and due to the courred at the time	date and place	and during	he/cade(s)	
Med	29b. Signatury and title of certifier		out to the same		29c. Licen	se number		29d. Date sign	ed (Month, D	ay, Year)	
	1/ Laur	Jorke	w	ed all	(OCME .		FEBRUA	RY 21,	1999	
	30. Name and addgess of person wh	o completed cause of o		la) (Type, Print)							
0	TYARON LO	KE, MI) 111	Penn St	reet.	Baltim	ore, Mary	Land 212	201		

DHMH 16 Rev 6/95



Please Type or Print In Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:00AM FEBRUARY 19, 199 Melvin Moore, Sr. /Medical 4a Fecility Name (If not institution, give street end number, 4b. City, Town, or Location of Death / 4c. County of Death Examiner BALTIMORE City CATON MANORGENESIS ELDER CARE n/a | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 8 / 30 / 1926 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1X M 2□ F Months Yrs. 216-20-9350 Usual Residence of Decedent MD 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore n/a MD 1 Yes 2 No Director 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 21223 USA 1954 W. Fayette St. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? ★□∜es 2□ No If Yes, Give Year or Dates: ₩₩II 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Ricen, etc.) Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) College (1-4or 5+) construction Self Employed 8 18. Mother's Name (First, Middla, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Bertha Hawkins William Moore 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1954 W. Fayette St. Balto., Md. Mary Moore/Wife 20b. Place of Disposition (Name of cematary, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State 2./24 Owings Mills, Md Garrison Forest V.A. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility James A. Morton + Sons 21. Sonature of Funeral Service Licensee Party Entur the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and or heart failure. List only one cause on each line. Q. W Balto, Nd. 21217 Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition rasulting in death) Examiner Sequentially list conditions, if any, leading to immediata causa. Entar Undarlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medicai Due to (or es e consequence of): Part IJ-Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? oronary Direare 1 Yee 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28c. Injury at Work? Certification: 1 Naturai 2 Accident 5 Panding invastigation 1 ☐ Yas 2 ☐ No 6 Could not be datarminad 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 10x Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Certifier Medical (Check only one)

Division of Vital Records, or Attending Physician: Hospital To the Hosp within 24 ho To the Fune completely fi

Funeral

Director

the Maryler

item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Medical Examinar naust be notified as

permit. Pages 1 end 2 should be filed within Depertment of Health and Mental Hygiene. Important: If Item 27 Is marked other than "

any injury or

Physician /Medical

Examiner

ettending physicien for use as the burie

signed by t

funeral

After t

24 hours after death.

State Registrar

CN.CYRIAC-M-D 31. Date filed (Month, Day, Year) FEB 2 2 1999

29b. Signature and title of certifier

8109 RITCHIE WY, 32. Segistrar's Signature

30, Name and address of person who complated ceusa of death (Item 23a) (Type, Print)

29c. License number D21684

PASADENA, MD 21122

29d. Date signed (Month, Day, Year)

Market A Committee And Committee Com

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Item 18 Per FH FilmG796 3-9-99 ria Certificate of Death Reg. No: 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** GLADY5 NEILL 7:26 PM 18 FEBRUARY 1999 /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NORTHWEST HOSPITAL BALTIMORE RANDALISTOWN 8. Date of Birth (Month, Day, Year) Feb. 12, 1908 If Under 1 Year | If Under 24 Hrs. | 9. Birthplace (Stata or Foraign Country) Damaseus, Md. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10 M 2 F Days 91 Yrs. Director 577-38-0190 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits than "natural", or items 23s or 28s-f show the Madical Examiner must be notified at 1 √ Yes 2 No Md. Rockville Montgomery 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Ta 623 W. Lynfield Drive 20850 IISA Funeral 14. Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) e filed within 72 hours after d il Hygiena. other then "natural", or Item 1 ☐ Yes 2 ☐ Xeo If Yes, Give Year or Deles: 1 Never Married 2 Merried 1 ☐ Yes 2 X No Specify Specify þ White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 10 Grade permit. Pages 1 and 2 should be flie Department of Health and Mental Hy Important: If ham 27 is marked oths any injury or other traumatic avent, pages. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) 8 Sheckles Grace - Gupptle Walter Burns 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) 4652 Huntley Drive Ellicott City, Md. 21043 Robert W. Neill 20b. Plece of Disposition (Nema of cemetary, crematory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 1) Burial 2 Cremetion 3 Removel from Stele 2/22/99 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Cemetery Rockville, Md. 21 Signalities of Funeral Service Licenses 22 Name and Address of Facility 11824 Reisterstown Road Reisterstown, Md. 21136 ELINE FUNERAL HOME lone 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate tntarvel Between Onset end Deeth **Physician** /Medical Immediate Causa (Final ATHEROSCLEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in death) Examiner Due to (or es e consequence of) Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as e consequence of): Physician/Medical Due to (or as e consequence of) 2 188 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Ware autopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2X ER/Outpatient 3 DOA 27. Manner of Death
1 A Natural
2 Accident 28a. Dale of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Time of 28c. Injury al Work? edical Certification: 5 Pending investigation a after death.

I Director: Aft
od in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Localion (Street and Number or Rural Route Number, City or Town, Steta) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

that the death cartificate be executed Box 68760, Division of Vital Records, P.O. or Attanding Physician: To the Hospital o within 24 hours aff To the Funeral Di completely filled in

Peen has

this

death .

Baltimore, Maryland 21215-0020

State

Registrar

29b. Signature and title of certifier

(Check only one)

29c. License number D4349

29d. Date signed (Month, Day, Year)

21133

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

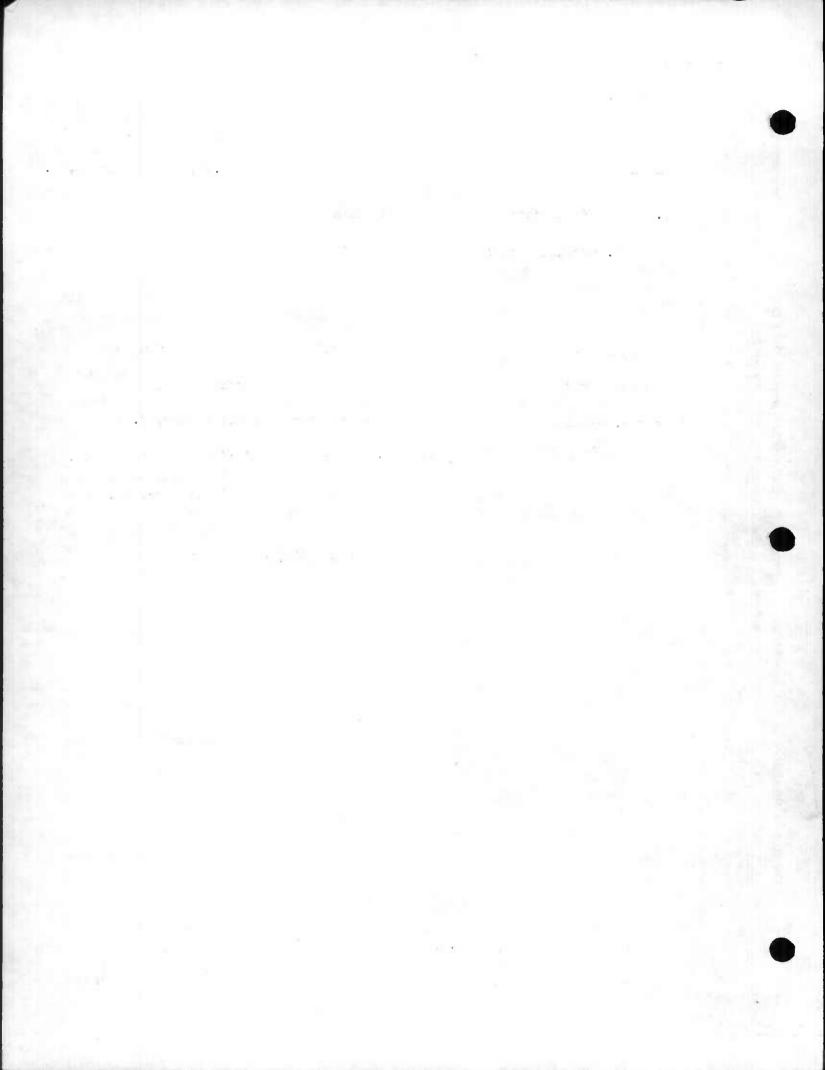
COURT OLD 5401 ROAD STO WN

31. Date filed (Month, Day, Year)

32. Registrer's Signature 1999 FEB 2.2

2000

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene

MILDRED	
NICHOLS	

Physici /Medic Examir

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Pyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 2008.

Baltimore, Maryland 21215-0020 Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician eNd completely filled in by the tunneral director, page 2 should be deliathed for use as the buriasit

Division of Vital Records, P.O. Box 68760,

Sta

1. Decedent's Name (First, Middle, Las	st)					2. Date of	Death	D	Vii.	3. Time of De
Mildred	Clar	ra		Nicho	1s	Month FEBRU	ARY	Day 18.19	Year 99	10:43P.
la Facility Name (If not institution, give	street and number)				4b. City, Town	, or Location of D	eeth	4c. County	of Death	
1519 BETHLEHEM AV	E				DUNDAL			BALTI	MORE	
5. Social Security Number 6. So			st birthday)	If Under 1 Yes		Hrs. 8. Date of (Month) Dec.	Birth Dey, Y	ear)	9. Birthpi Coun	lace (State or Fo
217 03 3717	□ M 2□ F	80) Yrs.			Dec.	23	1918	Ma	ryland
Usual Residence of Decedent 10e. Stete 10b. County		10c. City,	Town or Loc	cation					10	0d. Inside City L
M 1 1 D - 1 + 3 -				1 1.						1 ☐ Yes 2
Maryland Baltin 10e.Street and Number	nore	1	Ounda:	10f. Zip Code			100	. Citizen of V	Vhat Coun	21
1519 Bethlehem	Aunio			100	22-110	3				erica
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1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕅 N					n? (Specify Yes o Puerto Ricen, etc.)		k, White,	etc.
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Detes:		1	☐ Yes 2X N	o Specify:			Specify	Whi	te
15. Decedent's Ed	ucetion		16a. Deced	ent's Usual Occ	cupation		16	b. Kind of Bu	siness/inc	dustry
(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5	(4)	life. D	kind of work doi OO NOT use ret	ne during most o ired)	r working				
12	ŇA	,	Man	icuris	t		1	Nail :	Salo	n
17. Father's Name (First, Middle, Last)					18. Mother's	s Name (First, Mid	idle, Ma	iden Sumem	9)	
William		I	Lusk		Mar	у		G	odek	
19a. Informant's Name/Relationship (7	Type, Print)		19b. Mailin	g Address (Stre	et and Number	or Rural Route N	ımber, (City or Town,	State, Zip	Code)
Norman G. Nicho	1s(HUSBA					Ave. Du				
20a. Method of Disposition		20b. Pla	netery, crem	sition (Name of natory or other p	olace)	Date	20	c. Location -	City or To	own, State
1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 🛣 Other (Specify	Orvot	St		nislau		Feb 23	Ва	altim	ore,	Md.
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The second of th Steem amilian area **Physician** /Medical Examiner

Physician

/Medical

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Funeral

Director

28a-f show

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natural, or

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Funeral

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death

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12 should be finance and Mental H

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permit. Pages 1 and 2 sh Department of Haelth and Important: If Item 27 Is m any injury or other traum page.

Baltimore,

Box 68760,

Records,

Division of Vital

and attending physician for use es the burial ed by the a ed by peen cartificete has

Physician/Medical Examiner

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Completed

Be

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Certification:

edical

1 ☐ Yes 2 ☑ No

27. Manner of Death

1 Natural 2 Accident

3 Suicide

4 Homicide

The law requires that the death certificate be executed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completely filled in by the funeral director,

Congestice Hypertension

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Cartifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature end title of certifier

Calapal

29d. Date signed (Month, Dey, Year) 29c. License number

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

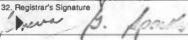
9105 Franklin Square A.N. Ralapati Drive #312. Baltimore 21237 31. Date filed (Month, Day, Year)

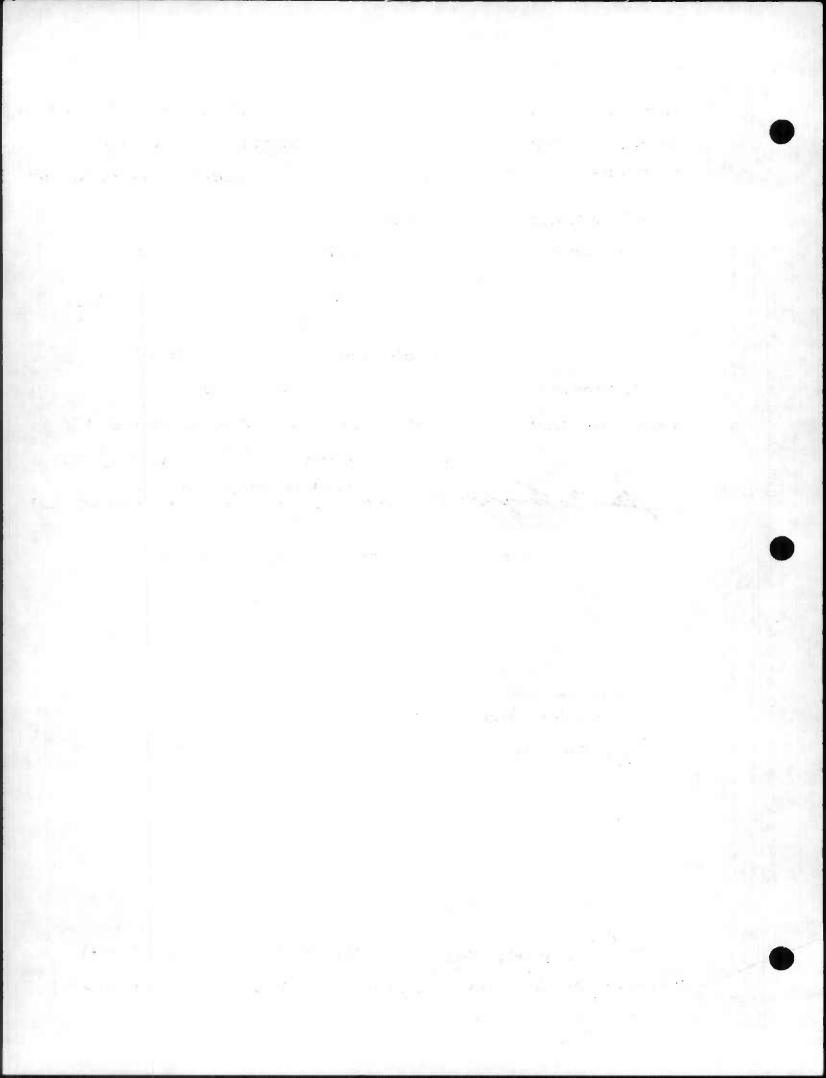
State Registrar

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5 Pending

Investigation 6 Could not be determined

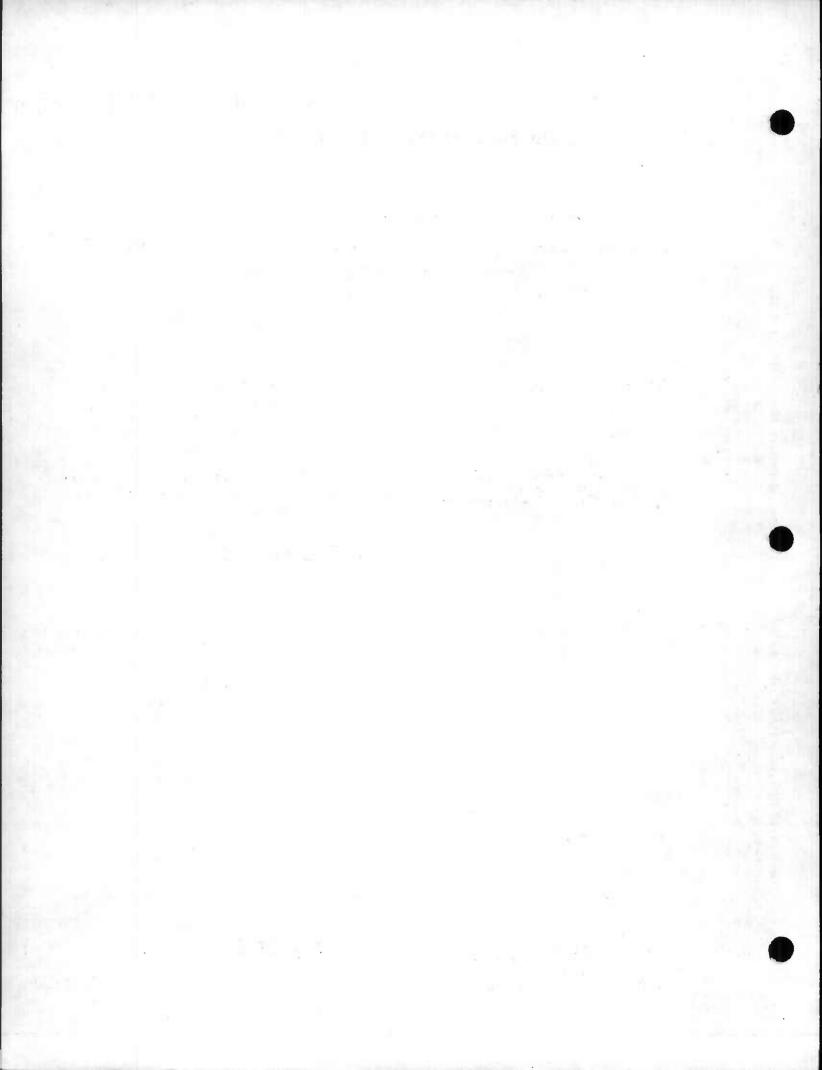




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death POWELL February 19, 199 **Physician** WILLIAM /Medical 4a Facility Nama (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Saltimore Hospita HODKINS The Johns H Under 24 Hrs. 8. Date of Birth (Month, Day, Jean) 34 July 22, 1936 5. Social Security Number 9. Birthplace (State or Foreign Country) Virginia 6. Sex 7. Aga (In yrs. last birthday) **Funeral** Days 229-44-1155 1 M 2 F 62 Yrs. Director Usual Residence of Decedent with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits il Hygiene, other then 'netural', or itema 23a or 28a-f ehow vent, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5116 Brinton Court 21045 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a empl injury or other traumatic event, the Medical Examinatory page. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 12. Was Decedent Ever in U,S. Armed Forcas? 11 Marital Status 1 Yas 2 No If Yes, Giva Yaar or Datas: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: by Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Collega (1-4or 5+) Elementary/Secondary (0-12) Communication Analyst **TBM** 18. Mother's Nama (First, Middle, Maiden Sumame) 17. Fathar's Nama (First, Middle, Last) Be William Henry Powell Mildred Barbee 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clara Barrett Powell (Wife) 6116 Brinton Court, Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 Burial 2 Crametion 3 Ramoval from Stata 4 Donetion 5 Other (Specify) Baltimore Washington Crem 2/22/99 Laurel, MD 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Fundral Service Libenses 5555 Twin Knolls Road, Columbia, MD 21045 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haert feilure. List only one cause on each line. **Physician** Immediata Causa (Final disaase or condition rasulting in death) /Medical T CANCER 6 MONTHS Examiner Examiner or Attending Physicien: The law requires that the death certificate be executed physician and the burial-transit Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of): 980 signed by the a Part fl. Other staniffcant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Be 25. Was casa rafarred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Unpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yas 2 No 2 ER/Outpatient 3 DOA this 27. Manher of Deet 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? After 1 Natural 5 Panding Invastigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fun 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Cartifiar 12 Critifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated.
2 In clical Examiner: On the basis of axaminetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatura and little of contine 29c. License number 29d. Date signed (Month, Day, Year) MN 30. Nama and address of person who complated causa of death (Item 23a) (Type, Print) JOITNS HOSPITAL, BACTMORE, MARYL SINGER HOPKINS 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State

DHMH 16 Rev 6/95

Registrar



Piease Type or Print in Black Indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Day 7:30pm FRED PAGE FEBRUARY 18,1999 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4031 FAIRVIEW AVE. BALTIMORE N/A If Undar 1 Yaar | If Undar 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) 8. Data of Birth (Month, Day, Year) 1 DM 2 □ F Months Hours Days 86 248-18-5343 2-15-13 S.C Usual Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. insida City Limits 1 Yas 2 No N/A BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 4031 FAIRVIEW AVE. 21216 USA 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2\text{\text{\$\infty}} No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Orlgln? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - American Indian. Black, Whita, atc. 1 ☐ Navar Married 2 X Married 1 ☐ Yas 2 ☐ No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) -12--8-MINISTER CHURCH 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) JOE PAGE JOSEPHINE GODBOLT 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) ALWORTHELL L. PAGE (WIFE) 4031 FAIRVIEW AVE. BALTIMORE, MD 21216 20b. Placa of Disposition (Nama of cemetary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) NATIONAL MEM. PARK 2-25-99 LAUREL , MD. 21. Signatura of Funaral Sarvice Licansaa 22. Nama and Addrass of Facility PHILLIPS FUNERAL HOME, P.A. CFSP 1721-27 N. MONROE ST. BALTIMORE, MD 21217 23a. Part1. Program disaasa, or complications that ceused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrast, shock, or harm failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death Proplatic Concinuma metastate Immediata Causa (Final disaasa or condition rasulting in daath) Dehydration Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Disaasa or injury that Initiated avants rasulting in daath) Last Dua to (or as a consequence of): Vascular Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of causa of daath? generative Joint Disease 24a. Was an autopsy performed? 1 ☐ Yas 2 ☐ No 1 Yas 2 No 25. Was casa rafarred to medicel axaminar? 1 ☐ Yas 2 ☑ No 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how Injury occurred 28b. Tima of 1 Watural 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 Could not be datarminad 3 Suicida Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida 1 Cortifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as statad. 2 Madical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, end due to the ceusa(s) and mannar stated. 29a, Cartifiar (Check only one)

Records, P.O. Box 68760 Division of Vital Hospital or Attending P 124 hours after death.
 Funeral Director: After t

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Certification: To

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any Injury or other traumatic event, the Modical Examinating must be not that

Physician

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Baltimore, Maryland 21215-0020

To the Hospital within 24 hours a To the Funeral D Medical State

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Registrar

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29b. Signatura and titla of certifiar

MD

29c. Licansa number

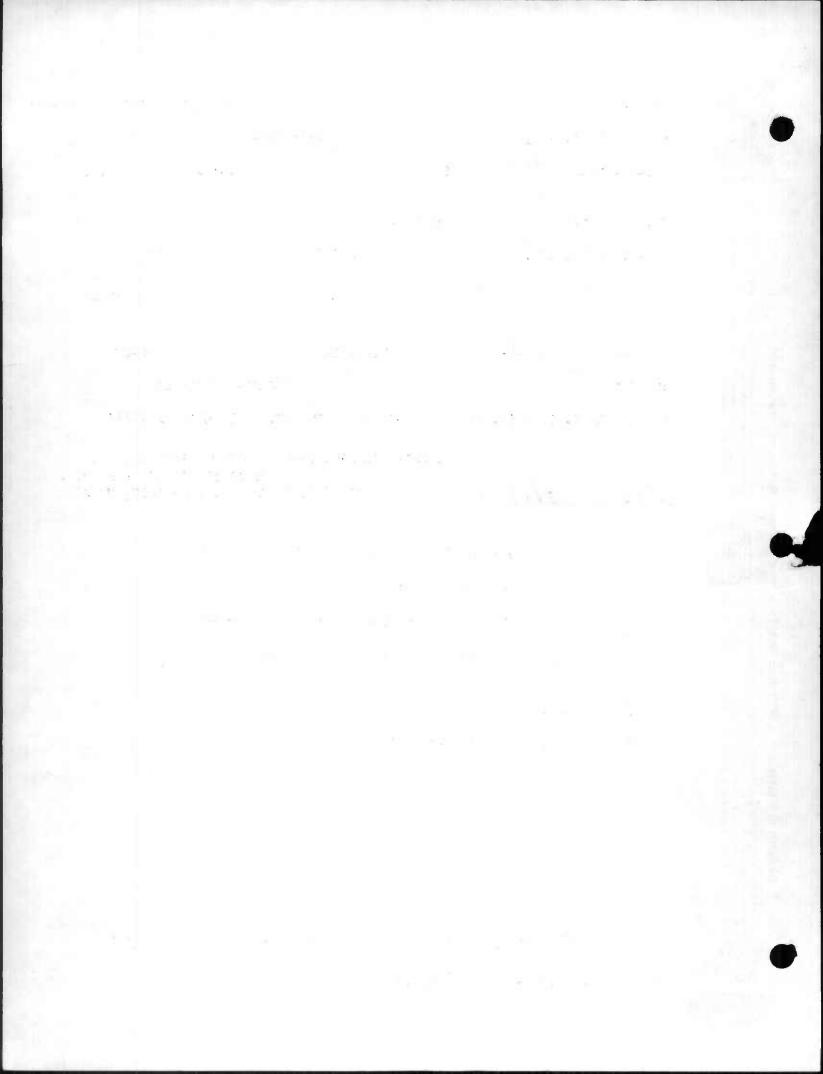
29d. Data signad (Month, Day, Year)

30. Nama and addrass of person who complated causa of daath (Item 23a) (Type, Print)

821 N. Entaw 87 Finte 308 Balt MD 21201

31. Data filad (Month, Day, Year) 32. Registrar's Signatura 1999 FEB 22

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Data of Deeth Month **Physician** Katherine Pietruska 18, 1999 4c. County of Deeth 9:15 P.M FebRUARY /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Deeth Examiner CenTER | Kosed 4/e

If Undar 24 Hrs.

Hours Min.

8. Data of Birth
(Month, Dey, Yeer) BATTIMORE HOSPILAI TRANKLIN ZUARE 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1□M 2√2F Months Days 217-92-4109 86 Director April 13, 1912 Maryland Usual Residance of Decedent 10d. Inside City Limits 10c. City, Town or Location 10e State 10h County must be notified at 1 Yas 2 No Directo Maryland Baltimore Baltimore 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 1205 E. Homberg Avenue 21221 U.S.A. 12. Wes Decedent Evar In U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxicen, Puarto Rican, etc.) 14. Rece - American Indian, traumatic event, the Madical Examiner. Black, White, etc. 1 Yes 2010 If Yes, Give Yeer or Detas: 1 Naver Married 2 Married ò 1 ☐ Yes ZENo Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced "naturel", 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) homemaker Own Home 5 18 Mother's Name (First, Middle, Meiden Sumeme) 17. Fethar's Neme (First, Middle, Last) KATheRINE permit. Pages 1 and 2 should be f Department of Health and Mental H Paul Pietruska Buczinski Anna 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Margaret Riessler (sister) 353 Oberle Avenue, Baltimore, Maryland 21221 20b. Placa of Disposition (Name of cometery, cremetory or other place)
Sacred Heart of Jesus 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removei from Steta 02-22-99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licansee 22. Neme end Address of Facility Bruzdzinski Funeral Home, P. A. 23a. Peril. Enter the disease, or complications and caused an each of data. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Physician /Medical Immediate Cause (Final AccidenT a CEREBROVASCULAR disease or condition resulting in deeth) Examiner Examiner DISEASE TheroscleRolic physician and s the bunal-trans Sequentially list conditions, if any, laeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avants resulting in deeth) Lest Due to (or es e consequence of): Physician/Medicai Due to (or as e consequence of): use as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? ad by the 1 Yes 2 No 3 Probably 4 Unknown CORONARY ARTERY Disease signed I à 24b. Were eutopsy findings availabla prior to completion of cause of deeth? Completed 24a. Was an eutopsy ATRIAL FIBRILLATION 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attanding Physician: 25. Wes case reterred to medical axaminar? Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Rasidenca 6 Othar (Specify) 1 Yes 2 No this 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Naturel
Accident To the Hospital or Attanding within 24 hours after death.

To the Funeral Director: Afte completaly filled in by the fun 5 Panding 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify) 4 Homicide † Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edicai 29a. Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier 29c. Licansa number D0051356 February 18, 1999 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 9000 FRANKlin SquARE DR. BALTIMORE, MARYLAND 21237 DR. Michael 1 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State

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Registrar

FEB 2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month JOSEPH J. READDY :38 Am 99 /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** BALTIMORE FUTURE CARE HOME WOOD N/A 6. Sex 1XXM 2□ F If Under 1 Year If Under 24 Hrs.

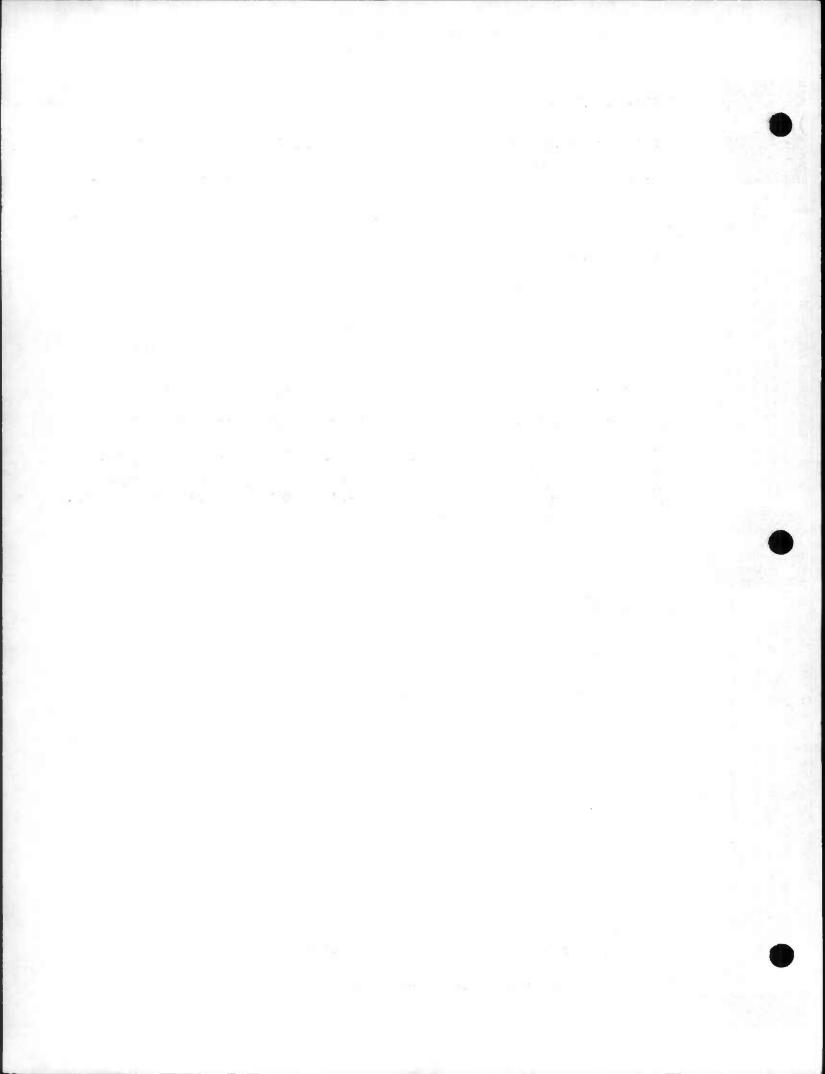
Months Deys Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** Deys Months 86 Yrs. Director 218-01-8353 Usuel Residence of Decedent 3 - 3 - 12PA. with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1X Yes 2 No N/A Director BALTIMORE MD. 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Pages 1 end 2 should be filed within 72 hours effer death 1 Department of Health and Mental Hygiene. Important: If flem 27 is married other than "nature!" and any fullury or other traumatic average. Funeral 4410 ELDERON RD. 21215 USA 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Meritel Status 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 □ Yes 2 □ No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) CUSTODIAN SCHOOLS -12--0-17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be P JAMES READDY GRACE (UNKNOWN) 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) MARY PERRY (DAUGHTER) 4410 ELDERON RD. BALTIMORE, MD 21215 20b. Plece of Disposition (Name of cametery, cremetery or other piece 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremation 3 Removel from Stete MD. NATIONAL MEM. PARK 2-20-99 LAUREL. MD. 4 □ Øonetion 5 □ Other (Specify) 21. Signature of Funerel Service Licensee 22. Neme end Address of Fecility REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MD 21217 Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or head failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel notionyopath disease or condition resulting in deeth) Examiner Examiner physician end the buriel-transit Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Couse (Diseese or Injury that Initiated events resulting In deeth) Last Due to (or es e consequence of) Physician/Medical Due to (or es e consequence of) USB 85 cate has been signed by the attending page 2 should be detached for use es Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Joseph Readon 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Micknown à 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? After this certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifical completely filled in by the funeral director, Be 25. Wes case referred to medical 28. Pleca of Deeth (Check only one) Other: 4 Stursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how Injury occurred 1 Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide 12 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29e. Certifier 29b. Signeture and title of certifler 29c. License number 29d. Dete signed (Month, Dey, Yeer) Taymord White D 47683 30. Name and addless of person who completed cause of deeth (Item 23a) (Type, Print) Raymond Miller 31. Date filed (Month Day, Year) FEB 2 2 25 Man smeet Smte MD 200 32. Registrer's Signeture State 1999 Registrar

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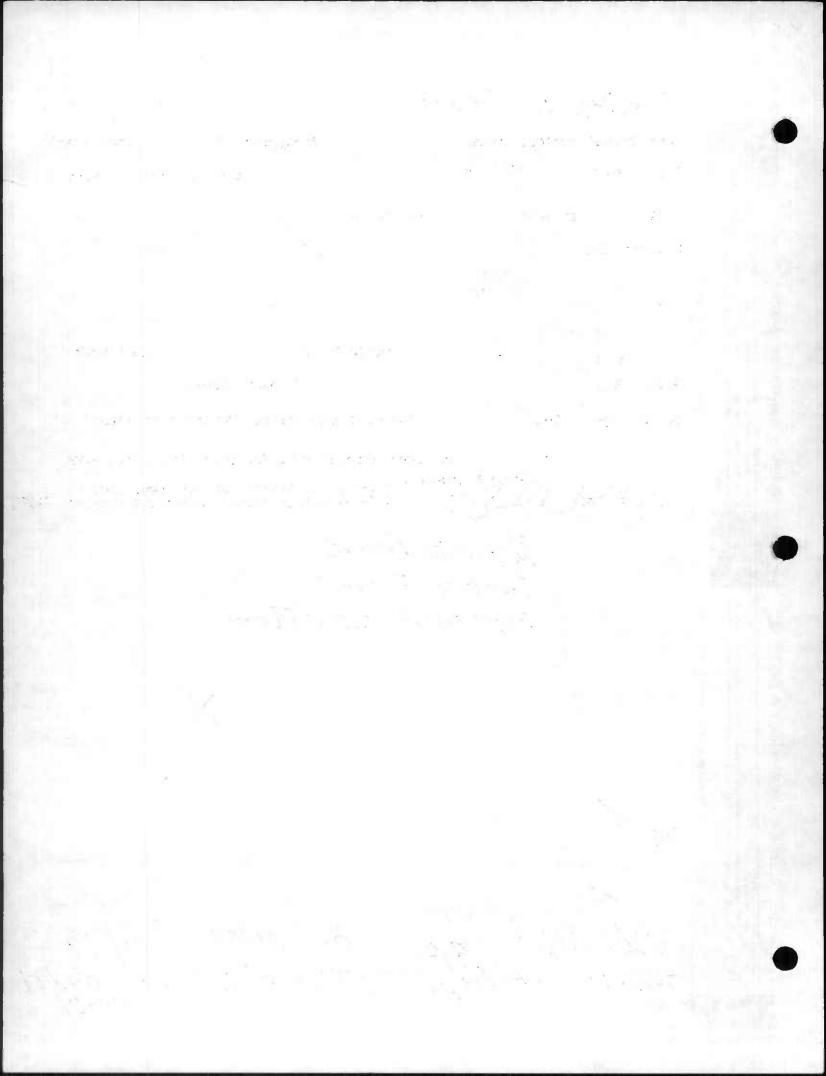
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. -3. Time of Deeth 1. Decedent's Name (First_Middle, Last) 2 Date of Death Month **Physician** 10/ /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number 4c. County of Death Examiner Anne-Arundel Medical Center Annapolis, MD Anne-Arundel If Under 1 Year If Under 24 Hrs.

Months Devs Hours Min. 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Dev. Year) **Funeral** Months Deys Hours 1 M 200 Yrs. 232-24-7307 80 Director April 5, 1918 W. Va Usuet Residence of Decedent with the Marylend 10a State 10h Count 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f ahow treumstic event, the Medical Examinal must be notified at VA Tazewell Pocahontas 1 Yes 2 □ No Director 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number P.O. Box 555 24635 USA Funeral death 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Marital Status Bleck, White, etc. purmit. Pages 1 and 2 should be filed within 72 hours efter Department of Health and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 1 ☐ Yes ≥ No Specify: White þ ₩idowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementery/Secondery (0-12) Coltege (1-4or 5+) Craft Person Craft Work 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gaspar Nagy Susanna Moinar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Joseph Sayko / Son 144 W. Church Street, Frederick Maryland21701 other 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 5 Roselawn Cemetery Feb. 26, 1999 4 □ Donetion 5 □ Other (Specify) Princeton, W. Va Victor P. Doda, Jr. 22. Name end Address of Fecility any Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as e consequence of Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury Physician/Medical that initieted events resulting in death) Last use P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 2□ No 3 Probably 4 Unknown Yes PV Division of Vital Records. 8 24b. Were autopsy tindings eveilable prior to completion of cause ot deeth? 24a. Wes en eutopsy performed? Completed certificete has 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? director Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 1 Yes this 27. Manner of Deal funeral 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Date of tnjury (Month, Dev Year) 5 Pending investigation 1 Yes 2 No deeth. 2 Accident efter deeth Director: 6 Could not be 3 Sulcide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 THomicide 5 24 hours Funeral Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie edical (Check only one) To the Vithin 2 29d. Date signed (Month, Day, Yeer, 32. Registrar's Signeture

DHMH 16 Rev 6/95

Registrar



Box 68760.

Division of Vital Records, P.O.

NAME:

Hospital or Attanding Physician:

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To the Funeral C

Baltimore, Maryland 21215-0020

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	Usual Residence									500	44.00	
fled at	MD MD	10b. County			Town or Location Baltimore City						10d. Inside	
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Examiner on by Funer		arried 2 Married 4 Divorced	12. Wes Deced Armed Ford 1 Yes : If Yes, Give Year or Da	ces? % ExNo		Was Decedent of Yes, specify Co □ Yes 2554			ecify Yes or No Ricen, etc.)	0-		American Indian White, etc. White
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o Be	17. Fether's Nam John B				18. Mother's Name (First, Middle, Meiden Surneme) Mary Hughes							
othar traumat	19a. Informent's Patrici		g Address (Stre B Haver									

Doda, J22. Name end Address of Fecility 21. Signature of Funeral Service Licensee Victor P. Charles L. Stevens Funeral Home, Inc. 1501 East Fort Ave. Baltimore Maryland 21230 leath. Do not enter the mode of dying, such as cerdiac or respiretory errest, 23e. Pert1. Enter the disease, or complications that traused the shock, or heert failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** UROSEPSIS /Medical Immediete Ceuse (Final disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting In deeth) Lest Due to (or es e consequence of): Due to (or as e consequence of): signed by the a Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Be Completed by 24b. Were eutopsy findings eveileble prior to 24a. Wes en eutopsy performed? completion of ceuse of deeth? 1 Yes 2 No 1 Yes 2 No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 □ ER/Outpetient 3 □ DOA 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 MNaturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homloide edical 29e. Certifier

12 Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Exeminer: On the basis of exeminetion end/or investigetion, in my opinion, death occurred et the time, dete end place, and due to the ceuse(s) end menner stated. (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier

MaukanTe

D46704

Baltimore Maryland

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Birthplece (State or Foreign Country)

10d. Inside City Limits 1 √ Yes 2 No

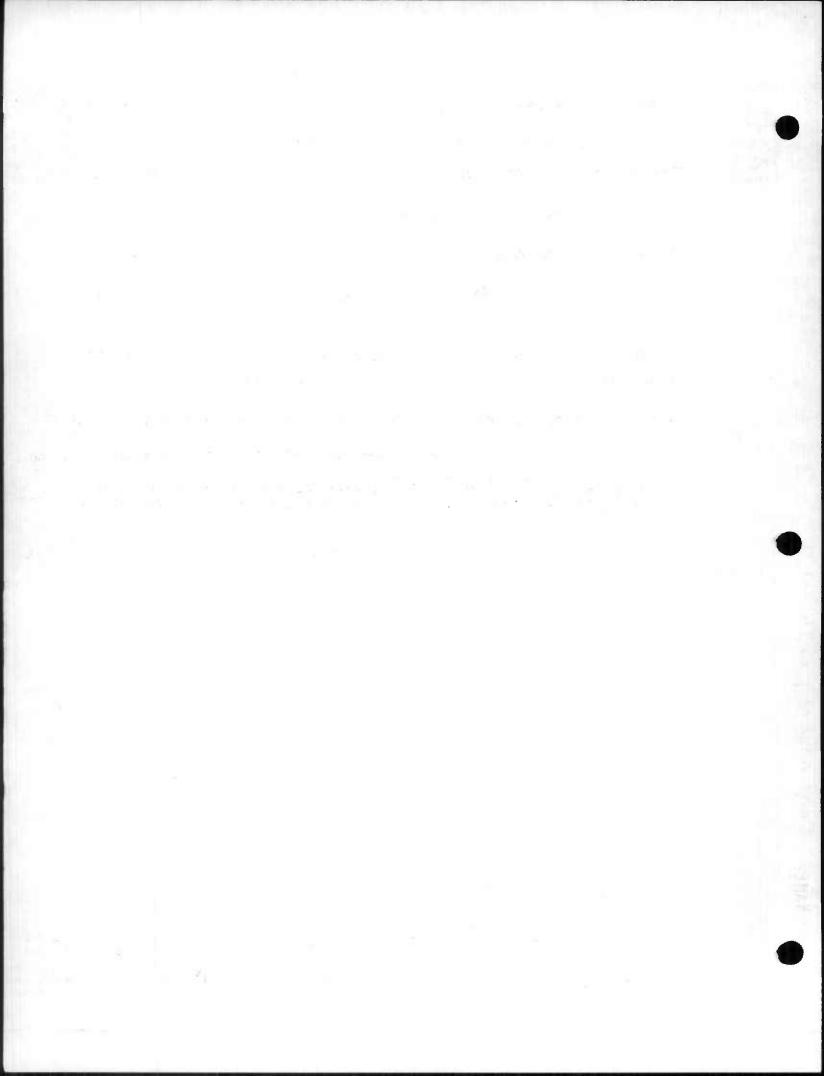
21229

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30. Name and address of person who completed cause of death (Item 23e) (Type, Print) AGNES HOSPITAL MUTOMBO 2 32. Registral's Signeture 31. Date filed (Month, Dey, Year)

State Registrar



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygien € ○ Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Dev **Physician** Anna Louise Starratt 4:45 Am 20 feb 1999 /Medical 4s Facility Name (If not Institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** Ba Himon City Sinai Hospital If Under 1 Year | If Undar 24 Hrs. 7. Aga (In yrs. last birthday). 5. Sociel Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 M 2 KF 215-54-0691 Director Oct. 6, 1910 Austria Usuel Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show Md. Sykesville Carroll 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? parmit. Pages 1 and 2 should be filed within 72 hours after deeth with t Dapentmant of Health end Mental Hygiena. Inportant: If item 27 is marked other than "natural", or items 23s or 2 any injury or other traumetic event, the Medical Examiner must be in page. 21784 7200 3rd Ave. Cottage C 119 U.S.A. Funeral 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian 11 Meritel Status Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed 16e. Decedent's Usuel Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamentary/Sacondary (0-12) College (1-4or 5+) Hospital Registered Nurse 12 18. Mother's Nema (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Pauline Medvig Henry Mazur 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) Clergyman 1 E. University Parkway, Baltimore, Md. 21218 Frederick J. Hanna 20e. Method of Disposition Plece of Disposition (Neme of camatery, crametory or other place) 20c. Location - City or Town, Stata 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from State Metro Crematory Feb. 22, 1999 Baltimore, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Nama and Address of Fecility Eckhardt Funeral Chapel 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Md. 21117 Approximete Intervel Betwean Onset end Death **Physician** /Medical Immediate Cause (Final disaasa or condition rasulting in daath) 10 days Treumonia Examiner Due to (or es e consequence of): Examiner Iulmmary Edema 20 days The law requires that the death certificate be axecuted ettending physician end for use as the burial-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disaese or Injury that initiated events resulting in daath) Last Due to (or es e consaquence of) Artery Disease Cormany 10 years Physician/Medicai I Due to (or es e consequence of) Division of Vital Records, P.O. Boy signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably Wunknown þ 24b. Were eutopsy tindings eveilebla prior to completion of cause of daath? should Completed 24a. Wes an eutopsy performed? certificata has b 2 No 1 ☐ Yes 2 No 1 Yes 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only ona) Be 1 Yes 2 No Hospital: Other: 4 Nursing Homa 5 Residence 8 Other (Specify) Minpatiant 2 ER/Outpatient 3 DOA To this 28e. Dete of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Menner of Deeth 28c. Injury et Work? Certification: After 1 Naturel Hospital or Attending 5 Pending investigation 1 Tyes 2 No deeth 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Sulcide Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) in by after 4 | Homicide 24 hours Certifying Phyeician: To tha best of my knowledge, death occurred et the tima, dete end plece, end due to the cause(s) and mannar as steted.

2 Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, death occurred et the time, date end place, and dua to the cause(s) end mannar stated. edicai 29a. Certifiai completely (Check only one) To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatury and title of certifier garllar Feb 20, 1999 Res 000 30. Name end eddress byperson who complated causa of daeth (Item 23e) (Type, Print) Hospital Baltimore City, ul 21215 SANJOG 5. PANGARKAR 31. Date filed (Month, Dey, Year) 32. Registrer's Signature Registrar

Married arrest mark Way to Sans restant or f Cornel 48.7 4.515 3.50 richiesof this ectrol, r. Britsfick G. Hanne Clearment of C. Lidreswitt French, Islands, 14. Flald THE CONTRACTOR, 22, 224 CHESTER, M. C. 1000

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Day Month Vear Deborah Emma Singer 11:30a.m. February 17, 1999 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 1 Bowline Court Baltimore Baltimore If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Months Days 1 M 2X F 38 Yrs 215-90-9434 Baltimore. Md. July 1, 1960 Usual Residence of Decedent 10b County 10c. City, Town or Location 10d Inside City Limits 1 Yes 2 No Md. Baltimore Baltimore 10a Street and Number 10g. Citizen of What Country? 10f. Zip Code Bowline Court 21236 United States 12. Wes Decedent Evar in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Stetus Bleck, White, etc. 1 Tes 2 No If Yes, Giva Yeer or Detes: 1 Nevar Married 2 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Supervisor 8 Health Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Nema (First Middle Last) Frank Collurafici Elizabeth M. Friedel 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Richard F. Singer (Husband) 1 Bowline Court Baltimore, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from State 2/22/99 Baltimore Maryland 4 Donetion 5 Other (Specify) Entombment Gardens of Faith 21. Signeture of Funeral Sarvice Licensee Milton, J Knight Jr 22. Name end Address of Fecility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 23a. Pert 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Deeth Immediate Ceuse (Finel disease or condition resulting in deeth) Cancinoma 6 month Due to (or es a consequence of) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Tos 2 No 3 Probably 4 Unknown 24a. Wes an autopsy performed? 24b. Were eutopsy lindings available prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Praesidence 6 Other (Specify)

Physician /Medical Examine

Physician

/Medical

Examiner

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Director

25a-f must be notify

Berns 23a or

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Pages 1 and 2 should be the ment of Health and Mental H lant: If them 27 is marked oth lany or other traumatic even

with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0020

Box 68760.

Division of Vital Records, P.O.

Examiner USB BS

The law requires that the deeth certificate be executed signed by the a certificate this After

Physician/Medical by Completed Be Medical Certification: To

1 Yes 2 No

27. Menner of Death 1 Neturel

2 Accident

3 Suicide

4 Homicide

or Attending Physician: 24 hours after deeth. filled in by Hospital within 24 ho To the Fune completely f \$ 0

State

Registrar

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated. (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner steted. 29b. Signatura and little of certifier

5 Pending

6 Could not be

invastigetion

Marshell a Trune, M.D.

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify)

28b. Time of

29c. License number

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 19 e bruken

Location (Street and Number or Rural Route Number, City or Town, State)

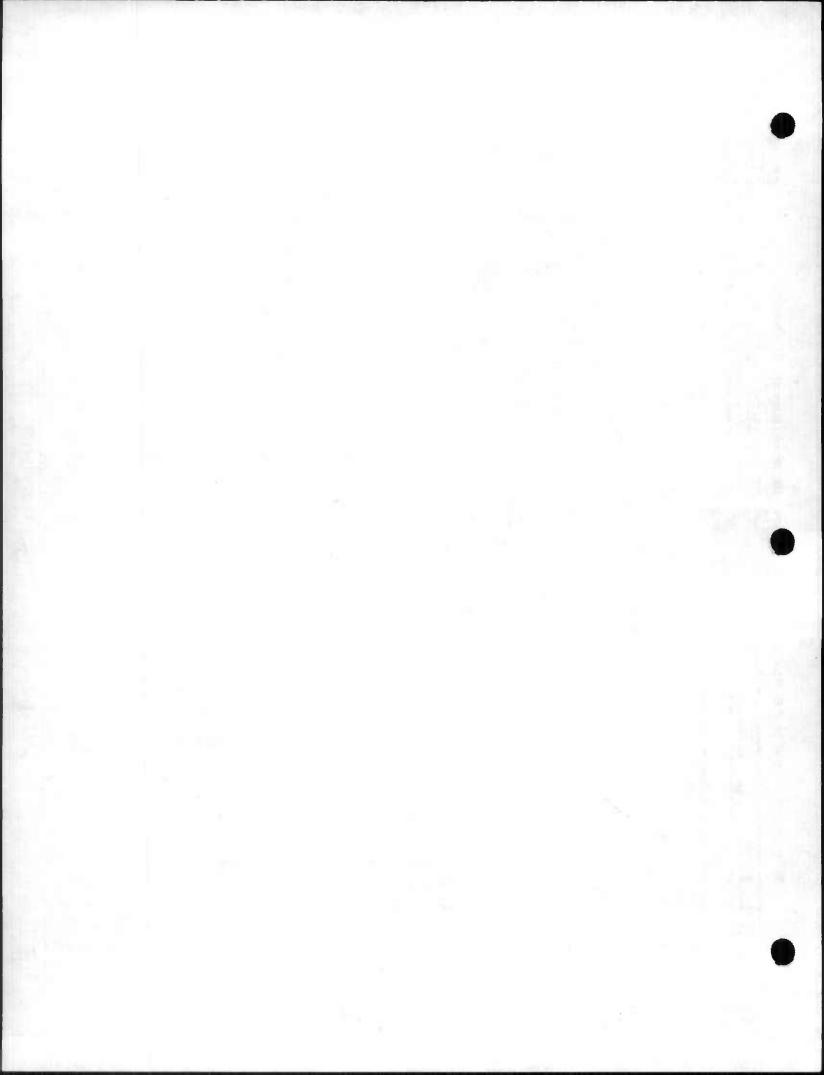
28d. Describe how injury occurred

30. Name end address of person who completed cause of death (item 23a) (Type, Print)

Marshall A. Levine, M.D., 4000 Old Court Road, Suite 306, Balto. Md. 21208

32. Registrar's Signature 31. Dete filed (Month, Dey, Year) 1999 FEB oorks

28a. Dete of Injury (Month, Day Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Yaa George F. Schweiger Sr. Feb. 1999 19 6:00AM 4b. City. Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Baltimore Arbutus 1256 June Road 6. Sex → M 2□ F If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 9. Birthplaca (Sta Country) ADT11 8, 1929 Maryland 9. Birthplaca (Stata or Foreign 5. Social Security Number 7. Aga (In yrs. last birthday) Days Hours 212-26-9008 Yes 69 Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 XNo Arbutus Maryland Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 21227 United States 1256 June Road 12. Was Decedant Ever in US51 Argued Forcas? UZ/ 1951 1 Byss 2 No If Yas, Giva 07/1953 Yaar or Datas: Was Dacedant of Hispanic Origin? (Spacify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amaricen Indian, Black, Whita, atc. 11. Marital Status 1 Nevar Marriad 2 Married 1 ☐ Yas 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Dacedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Printing Printing Pressman 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Mollie Wofle Walter Schweiger 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 1256 June Road Arbutus, Maryland 21227 Annette Schweiger (Spouse) 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata Meadowridge Memorial Park 02/22/\$9 Elkridge, Maryland 4 □ Donation 5 □ Othar (Specify) 21. Signatura of Funaral Sarviça Licensaa 22. Name and Addrass of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road Arbutus, MD 21227 23a. Part1. Entar tha diseasa, or complications that ceusad the shock, or haert failura. List only one cause on each line. at ceusad tha daath. Do not antar tha mode of dying, such as cerdiac or raspiratory arrest, Approximata Intarval Batw Onsat and Daath Immediata Causa (Final disaasa or condition rasulting in daath) Dua to (or as a consequence of): TENOSIS Sequantially list conditions, if any, laading to immediata ceusa. Entar Underfying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequance of) RESSION Dua to (or as a consequanca of) GAMMORATHY Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 6 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yas 2 □ No 25. Was cese refarred to medical axaminar? 26. Placa of Death (Check only one) axaminar 2 Othar: 4 Nursing Homa 5 Rasidance 6 □Othar (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Yaar) 27. Manner of Death 28c. Injury at Work? 28d. Describa how Injury occurred

Physician /Medical Examiner

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Physician/Medical

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Certification:

1 Natural 2 Accidant

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Physician

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permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglena. Important: If item 27 is marked other than "naturel", or frems 23a any injury or other traumatic event, the Medical Examiner must be any

Baltimore, Maryland 21215-0020

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Division of Vital Records, P.O. Box 68760,

Medical within 24 ho To the Fune completely f

29b. Signature and

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Certifying Physician: To the best of my knowledge, death occurred at tha time, date end place, and dua to the causa(s) and mannar as stated.

1 Yas 2 No

unther: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) 29d. Data signad (Month, Day, Year)

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

who complated causa of daath (Itam 23a) (Type, Print)

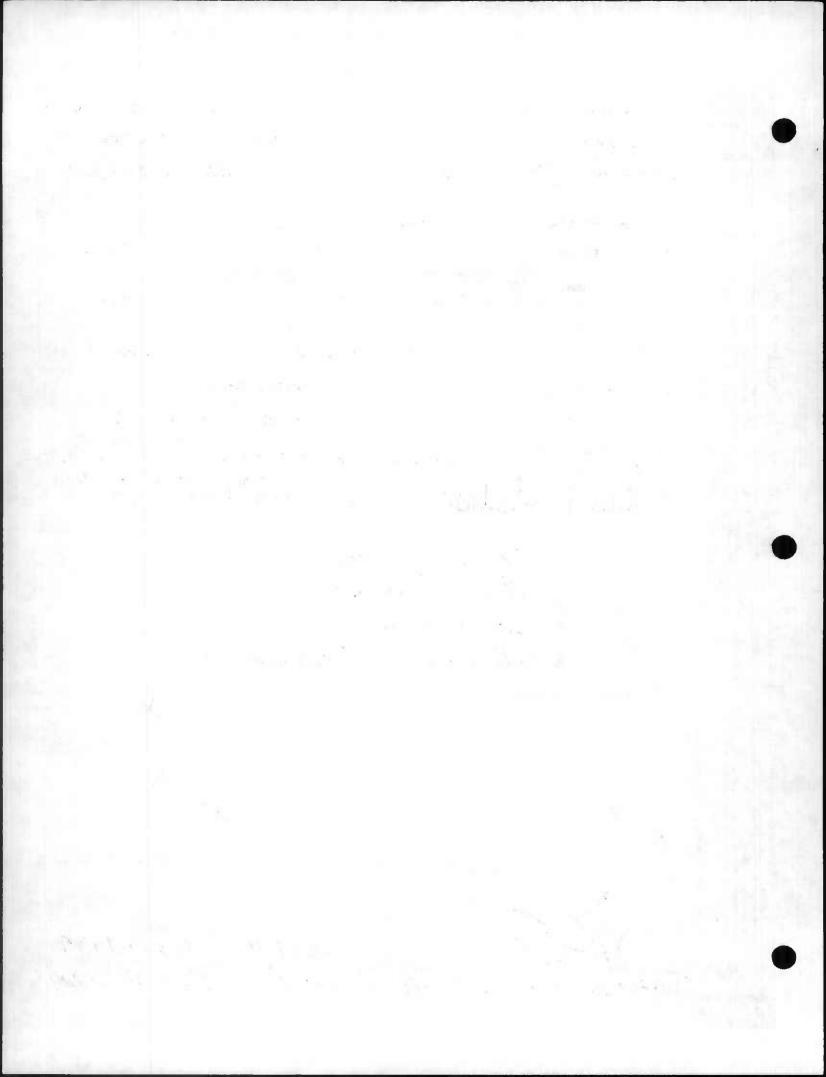
AUE, BALTMD 21229. OTLIKAR MD

State Registrar 31. Date filed (Month, Day, Year) 32. Ragistra's Signatura FEB 22

28h Time of

28a. Place of Injury - At homa, farm, street, fectory, office building, atc. (Specify)

To the



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'e Neme (First, Middla, Last) 2. Date of Death 3. Time of Death Month Day Vear Physician CLIFFORD 11:30 PM SELLMAN FEBRUARY 1999 15 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALT If Under 24 Hrs. MEMORIAL UNION HOSPITAL MORE If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Days Hours 216-54-5868 Months 1X M 2□ F Yrs. Director MARCH 6, 1951 MAR Usuel Rasidence of Decedent 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f ahow the Medical Examinar must be notified at GALTIMORE Yes 2 No Directo MARULAND 10e. Street and Number 100. Citizen of What Country? 10f. Zip Code 212 FAIRMOUNT AVENUE USA Funeral 14. Race - American Indian, Black, Whita, atc. 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 8 Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify. A 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiens Important: If fam 27 is marked other than "r any Injury or other traumatic aware Elementary/Secondary (0-12) Collega (1-4or 5+) COLLECTOR 12 HAGRADE BALTIMORE CIT 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be 1 FFORD SR. SWEETS MAR 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Flural Route Number, City or Town, State, Zip Code) BALTIMORE MD, 21244
ta 20c. Location City or Town, Stete A 6 WHIRLWIND COURT TONVA SELLMAN DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other plece) 1 ☐ Buriat 2 Cremation 3 ☐ Removel from Stete METRO CREMATORY
22. Name end Address of Fecility Other (Specify) 21. Signature of M Service Licens JOSEPH H. BROWN JR. FUNERAL 2 (40 N. FULTON AVE., BALTIMORE, M t anter the mode of dying, such es cardiac or respiratory arrest, HD. 2121 Approximata Intervel Between Onsel and Death 23a. Part1. Enter the disease, or complications that caused the deeth. Do not antar the mode of dying, such es cardiac or respiratory shock, or heart lailure. List only one cause on each line. **Physician** /Medical Immediete Cause (Final MYOCARDIAL INFARCTION 30 MIN disease or condition resulting in death) Examiner Dua to (or es a consequence of): CORONARY ARTERY BYPASS GRAFT AN MITRAL VALVE REPAIR 5 HOURS sician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of) physician Box 68760 ENDOCARDITIS AND MITRAL VALUE VEGETATION 3 WEEKS Physician/Medical the Due to (or as e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown END-STAGE RENM FAWRE ON HOTTODIALYSIS 24b. Wera autopsy lindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No Division of Vital Hospital or Attanding Physician:
 24 hours after deeth.
 Funeral Director: After this cartific. 25. Wes case referred to medical Be 26. Placa of Deeth (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 X Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the 29a. Certifier To the Hosp within 24 hos To the Fune completely fi (Check only one) niner: On the basis of examination and/or investigation, in my opinion, daath occurred et the time, data and place, and due to the cause(s) end manner stated. 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) Theener, nd TEBRUMEY 16, 1999 AT2438946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBIERT J. FALCONEL UNION MEMORIAL HOSPIAL BACTIMORE, MD

DHMH 16 Rev 6/95

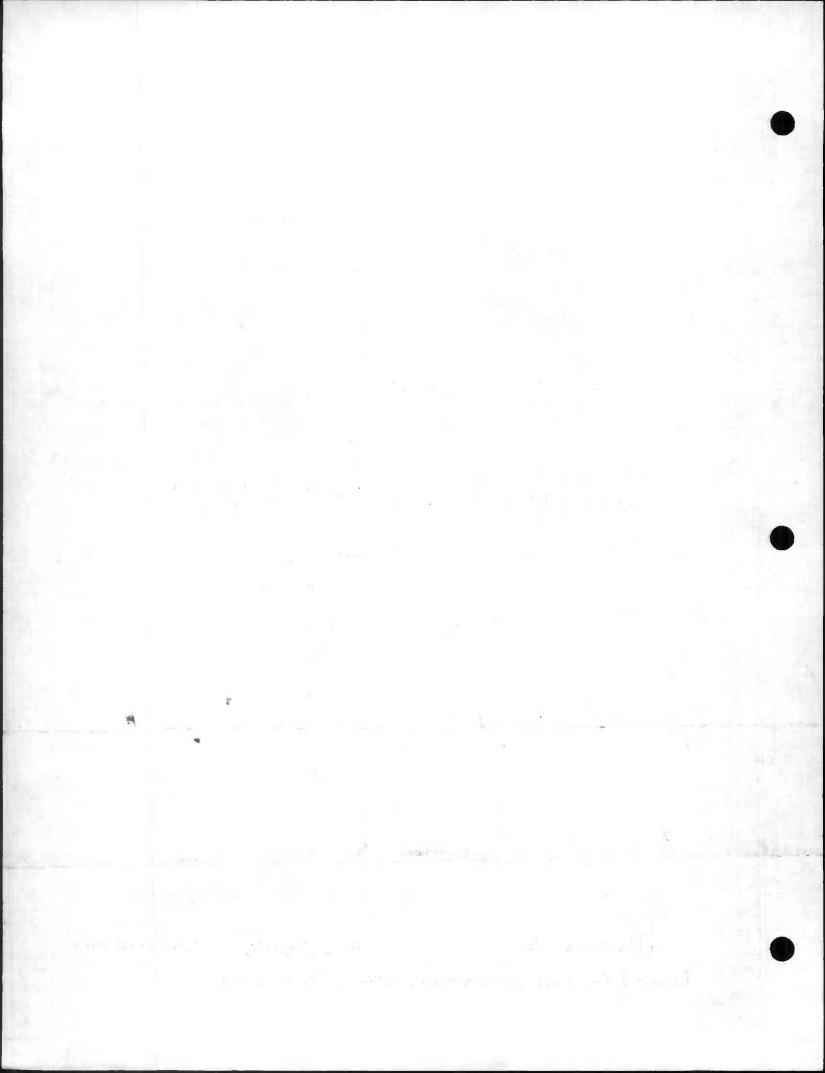
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Registrar

31. Dala filed (Month, Day, Year)

FEB 22

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) February 18, 1999 1:20 am Genevieve M. Schaub 4b. City, Town, or Location of Death 4c. County of Daath 4a Fecility Name (If not institution, giva straat and number) Franklin Woods Center Rosedale Baltimore If Under 1 Year | if Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1□ M 2 F 80 Yrs. 216 32 6679 Sept. 21,1918 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 ☐ Yes 2 No Maryland Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 819 Cedar Avenue 21221 USA 14. Race - Amarican Indian. 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yas 2 XNo Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Housewife Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Nama (First, Middle, Last) Harry Heil Genevieve McConnell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Elizabeth Hock (Daughter) 410 Katherine Avenue Baltimore, Md. 21221 20b. Placa of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 2/20/1999 Baltimore, Md. Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funaral Service License 22. Nama and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intarval Betwaen Onset and Death Immediate Cause (Final disaase or condition resulting in deeth) Due to (or as a consequence of) pertension Due to (or es e consequence of): Due to (or as a consequence of): 23b. Did tobecco use contribute to the cause of death? 3 Probably 4 Junknown 1 ☐ Yes 2 ☐ No ore-Vascular Accident 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of deeth? 1 ☐ Yes 2 HNo 1 ☐ Yes 2 ☐ No

Physician /Medical **Examiner**

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After this funeral

Hospital or Attending Physician: 24 hours efter death.

To the

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within 24 hours off To the Funeral Di completely filled in

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The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medicai

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Certification:

Medical

Physician

/Medical

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Funeral

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permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evaluation must be not feel as

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hospital:

25. Was case referred to medical examiner? 1 Tyes 2 No

27. Menner of Death 1 Naturel 5 Pending investigation 2 Accident

6 Could not be determined 3 Suicide 4 Homlcide 29a. Certifier

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28b. Time of

Other: 4 Nursing Homa 5 ☐ Residenca 8 ☐ Other (Specify) 28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

26. Piece of Death (Check only one)

(Check only one)

1 X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and menner stated. 29c. Licansa number

29b. Signature and title of certifier MB

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

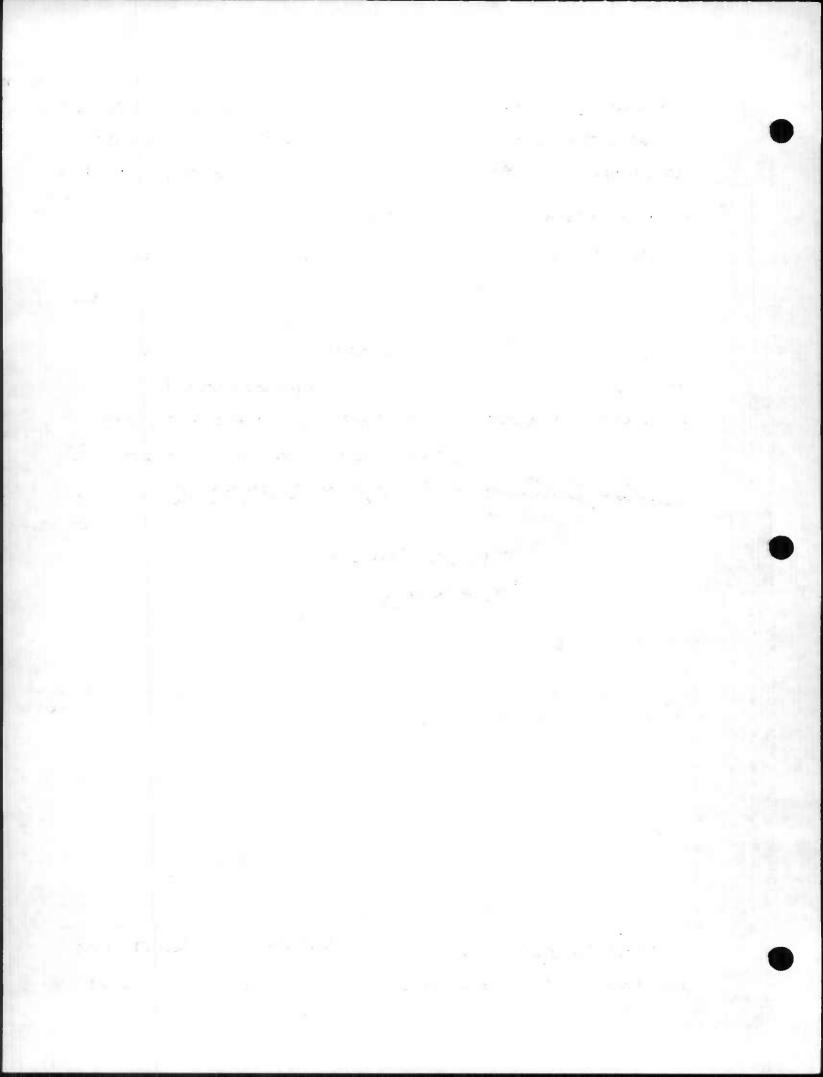
A.W. Ralapati. 9105 Franklin Square DR. #312. Baltimore. 21237

31. Date filed (Month, Day, Year)

FEB 2.2. 1999

32. Registrar's Signature

Registrar



Please Type or Print in Biack Indeiibie Ink. Assure Ail Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middle, Last) 2. Data of Deeth Month CLARENCE 23:20 E. THOMAS 1999 FEBRUARY 4e Fecility Nema (If not institution, give streat end number) 4b. City, Town, or Location of Death 4c. County of Deeth BALTIMORE SINAI HOSPITAL BALTIMORE If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Yeer) Birthplace (Stete or Foreign Country) 6. Sex 7. Age (In yrs. lest birthdey) If Undar 1 Yaar 5. Sociei Security Number 1X M 2 □ F Months Deys 49 01/14/1950 Maryland 214-56-1270 Usual Residence of Deceden 10d. Inside City Limits 10e Stete 10b County 10c. City. Town or Location 1 Yes 2 □ No Maryland Baltimore 10g, Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 21215 U.S.A. 3013 Garrison Ave. 12. Wes Decedent Ever in U,S Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indien, Bieck, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) Awning Company Welder 12 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Neme (First, Middle, Maiden Surnama) Clarence E. Thomas Alice B. Dorsey 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Delia Chew / Sister 20b. Place of Disposition (Name of cemetary, crametory or other place) Annapolis, Maryland 21403 Date 20c. Location - City or Town 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriai 2 Cremation 3 Removel from State 4 Donetion 5 Other (Specify) 02/24/99 Landsdowne, Maryland Mt. Zion Cemetery 22. Name end Address of Fecility 21. Signatura of Funeral Service Licenses The Derrick C. Jones Funeral Hm. 4611 Park Heights Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on a martine. Approximate Intervel Between Onset end Death Immediate Cause (Final diseese or condition resulting in death) BOWEL PEKFURATED SMALL Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in tha underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evallable prior to completion of causa of deeth? 24e. Wes en eutopsy 1 ☐ Yes 2 No 2 0 No 1 Yes 25. Wes case referred to medical axaminer? 26. Piece of Deeth (Check only ona) Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 26e. Dete of tnjury (Month, Dey Year) 26b. Time of 28d. Describe how injury occurred 27. Menner of Deeth 28c. Injury et Work? 5 Pending investigation 1 Naturei 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 26e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Records, P.O. Box 68760

signed by the page 2 s certificate or Attending Physicien: this funeral After deeth. 24 hours after deet Funeral Director: filled in by Hospital To the Hosp within 24 hor To the Fune completely fi

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/Medical

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permit. Page Depertment of Important: If any Injury or any Injury or

Physician /Medical

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Completed

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Certification:

edical

29a. Certifier

(Check only one)

Baltimore, Maryland 21215-0020

4 Knowin Co

State Registrar

29b. Signatura and title of certifiers

RCSITEMT 29c. License number SICH

The Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) end menner es steted.

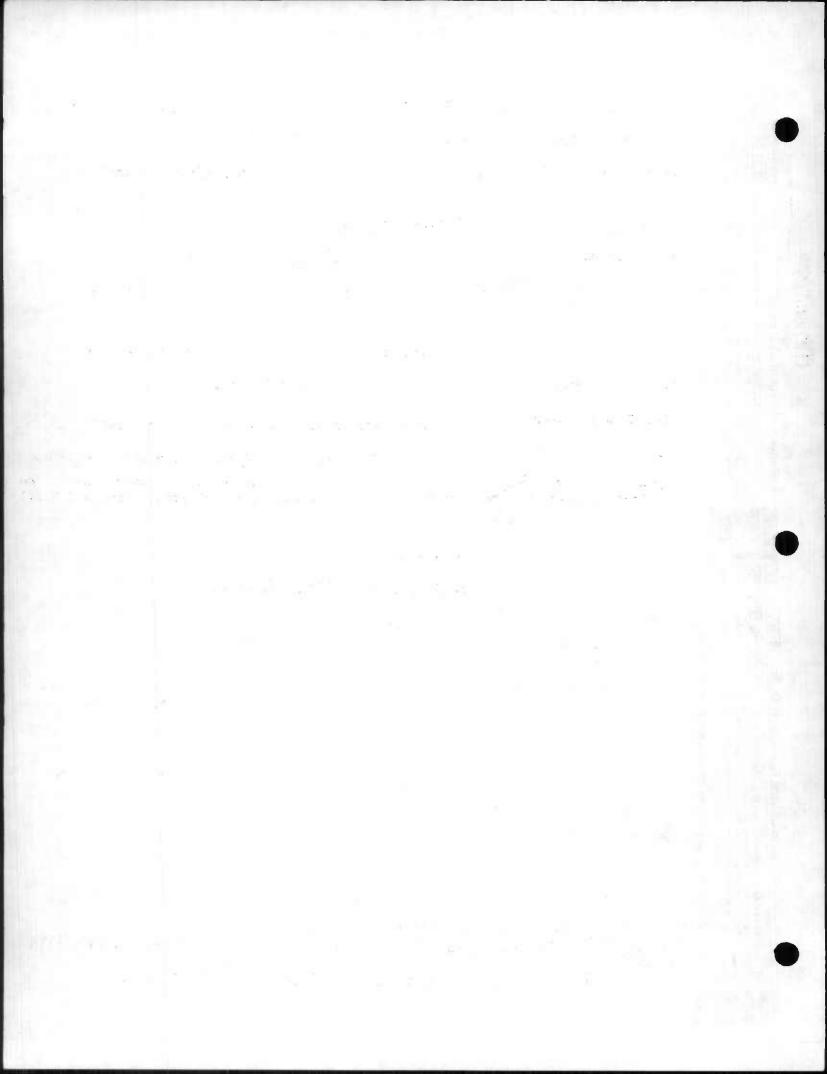
2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end menner stated. 29d. Dete signed (Month, Dev. Year)

Dr WATSON 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

BONNIE

ROGE Drive BALTIMORE

. UATSON 6602 32. Registrer Signatura 31. Dete filed (Month, Day, Year) FEB 2 2



Physician /Medical Examiner

Physician

/Medical

Examiner

10a. Stete

MD

Funeral

Director

r than "natural", or items 23s or 28s-1 show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "natural", or itel any loury or other treumatic event, the Medical Examine

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Physician/Medical Examine

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Certification:

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29a. Certifier

(Check only

The law requires that the death certificate be axe Box 68760. Division of Vital Records, P.O. or Attending Physician: this After after death. erel Director: A Hospital 24 hours

To the P within 2. To the P

Registrar

29b. Signeture end title of certifier PGY III RESIDENT V. Chambasella Rele

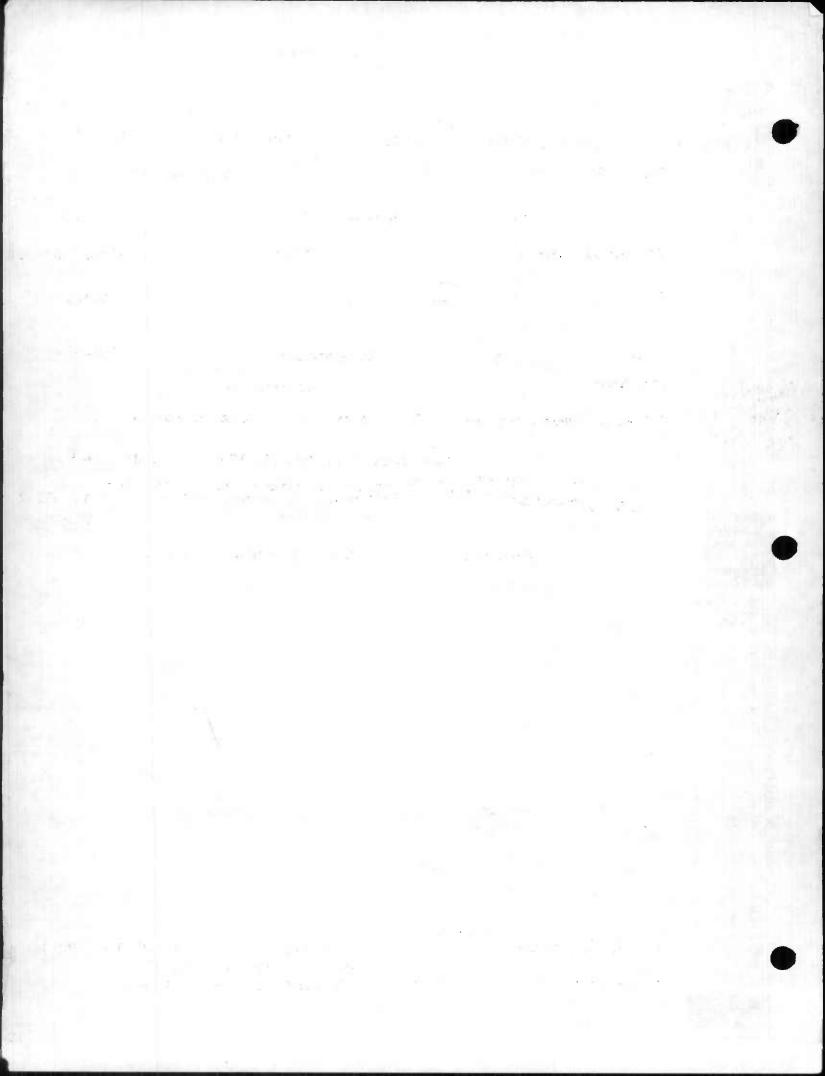
2 Medical Examiner: On the bests of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end pieca, end due to the ceuse(s) end menner steted. 29c. License number P10828

1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the ceuse(s) end manner es stated.

29d. Date signed (Month, Dey, Year) FEBRUARY 20, 1999

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 300 I S. HANOUER STREET CHANDRASEICHAR REDDY. VASAMAEDDY BALTIMORE

31. Dete filed (Month, Day, Year) FEB 22 32. Registrar's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. Not 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 18, 1999 February Frances N. Taylor 12:55 AM 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Pasadena Anne Arundel 7718 Lee Drive Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Min. 1□M 2XF Months Days Hours 66 Yrs. 212-30-7505 December 4 Maryland Usual Residence of Deceden 10a State 10b County 10c. City. Town or Location 10d Inside City Limits 1 ☐ Yes 2 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7718 Lee Drive 21122 USA 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: White 3 M Widowed 4 □ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Bookkeeper Church 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Bernard McNulty Marie Mueller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Reletionship (Type, Print) Maureen Boerner-Daughter 7718 Lee Drive, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. Feb 20 Baltimore, Maryland 22. Name and Address of Fecility Stallings Funeral Home, P.A. 21. Signature of Funeral Service Licenses 3111 Mountain Road, Pasadena, MD 21122 usch 23a. Part1. Enter the diseese, or complications that caused the death shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Lext Immediate Cause (Final disease or condition resulting in death) ZYrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4□ Nursing Home 5 ☐ Residence 6 □ Other (Specify) 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner Examiner ettending physicien and for use as the burial-trans Division of Vital Records, P.O. Box 68760, The law requires that the death certificete be Physiclan/Medical 80 signed by the e by should Completed peen s page 2 s hes within 24 hours after death.

To the Funeral Director; After this certificete it completely filled in by the funeral director, page Physician: Be To Certification: or Attending Hospital edicai the

Physician

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7 is marked other than "natural", or itama 23a or 28a-f show traumatic event, the Marical Examiner must be notified at

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2 should be filed within end Mental Hygiene.

permit. Papes 1 and 2 sh Department of Health and Important. If him 27 is m any injury or other traum ones.

Physician /Medical

Maryland 21215-0020

Baltimore

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural

2 Accident 3 ☐ Suicide 4 T Homicide

(Check only

31. Date filed (Month, Day, Year)

FEB 22

29a. Certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signature

1<mark>⊡ Certifying Physician:</mark> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier

29c. License number

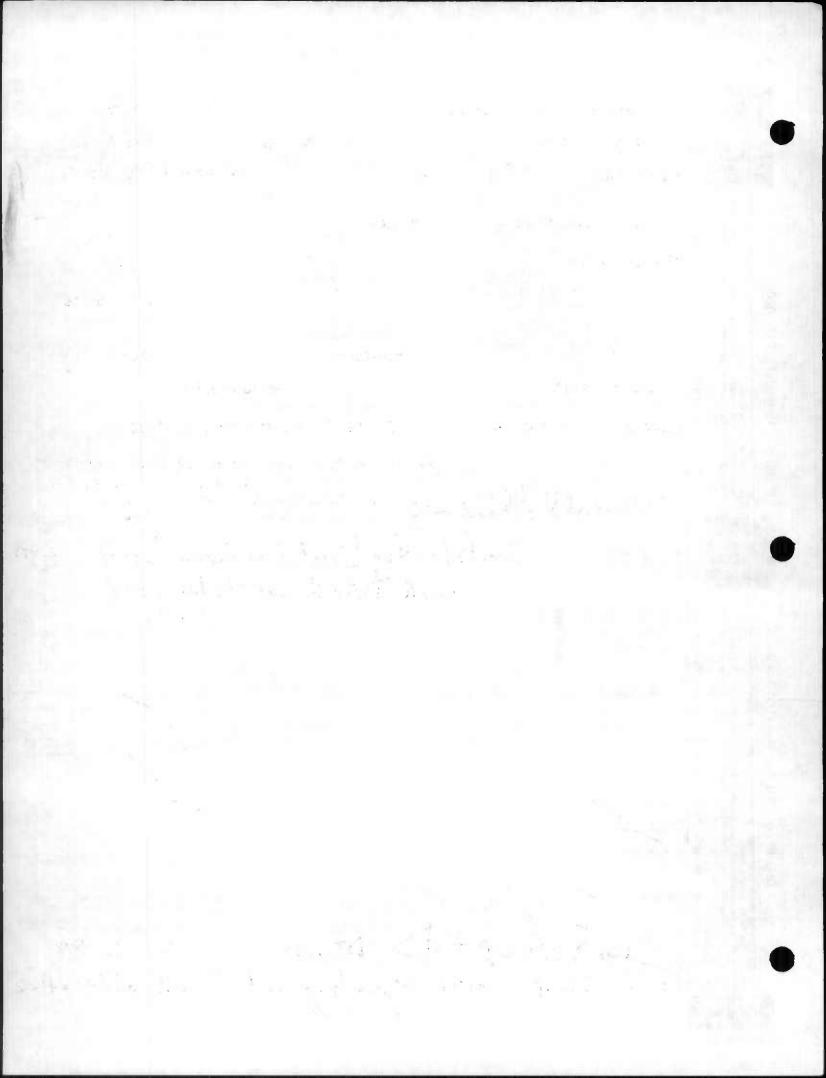
29d. Date signed (Month, Day, Year)

e and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

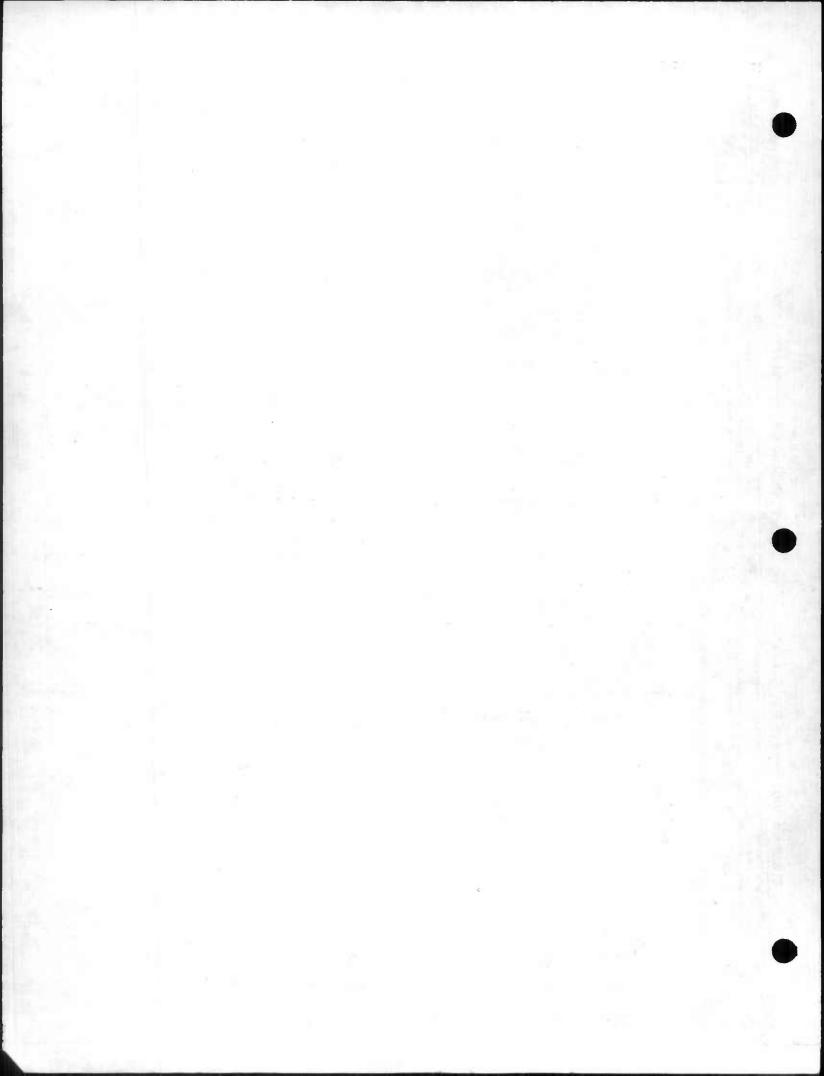


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene ITFM: #23 PART I PER MD G770 4-5-99 WR. Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Day Month **Physician** February 11 WILLIAMS MARK 1999 5:55 AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hosp. Fel Bultomore Johns Hopkins If Under 24 Hrs. 5. Social Security Number 6. Sax If Under 1 Year 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** 10M 20F Days **Months** Hours 213-76-0270 38 Director 08-17-60 MD Usual Rasidanca of Decedent death with the Maryland 10a. Stata MD 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show mass be nothing at NA Baltimore X X Yas 2 □ No Director 10e, Street and Number 10f. Zio Code 10g. Citizen of What Country? 7200 Bogley Road- Condo#303 21244 USA Funeral Herra: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decadant Evar in U,S. Armed Forcas? 14. Race - American Indian, Black, Whita, atc. filed within 72 hours after 1 ⊠ Yas 2 □ No If Yas, Giva 1 Navar Married 2 XMarried ò 21215-0020 1 Yas 2€No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates "natural" Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Secondery (0-12) College (1-4or 5+) Hygiene Engineer Techniciah 12th Grade College Student Disabled Baltimore, Maryland 18. Mother's Nama (First, Middle, Maiden Surnama) 17. Fathar's Nama (First, Middle, Last) . Pages 1 and 2 should be fill mant of Health and Mental Hant: If item 27 is marked oth lury or other traumatic even Be Chester Williams Sylvia Wright 19a. Intorment's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 21239 Sylvia Williams 1413 Winston Avenue Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, cramatory or other place) 20c. Location - City or Town, Stata M.D. 20a. Method of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata Department of Important: If any injury or 4 ☐ Donation 5 ☐ Othar (Specify) Garrison Forest VA Cem. 02-23-99 Owings Mills, 21. Signature of Funeral Service Licental 22. Nama and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E.North Avenue 23a. Part1. Enter the disease, or complications that caused the tree book, or heart tailure. List only one cause on each line. Approximete Interval Between Onset and Death Physician /Medical Immediata Cause (Finel Influenza 10 days A preumonita disaesa or condition rasulting in death) Examiner Due to (or as a consequence of): Examiner immediate cardrac arrest Sequantially list conditions, if any, leeding to immadiata causa. Enter Underlying Ceuse (Disease or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): The law requiras that the death certificate be exe P.O. Box 68760. **ASTHMA** YEARS Physician/Medicai Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 000 3 Probably 4 ☐ Unknown Kishner Transplant signed be del Records, þ 24b. Wara autopsy tindings available prior to completion of cause Be Completed funeral director, page 2 should 24a. Wes en autopsy performed? 1 ☐ Yas No 1 Yas 2000 Division of Vital or Attending Physician: 25. Was casa ratarred to medical examinar? 26. Placa of Death (Check only ona) examinar? Hospital: Inpatiant Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA After this 27. Memmar of Death 1 D Naturel 2 Accident 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Panding invastigation To the Hospital or Attendir within 24 hours after daath. To the Funeral Director: A completaly filled in by the fi 1 Yas 2 No daath. 6 Could not be datarmined 3 Sulcide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At home, term, street, tactory, office building, atc. (Specify) 4 Homicida The Certifying Physician: To the best of my knowledge, deeth occurred et tha time, date end place, end due to the cause(s) and menner as stated.

2 Medicat Exeminer: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar (Check only one) 29b. Signature and title of gertifler 29c. License number 29d. Data signed (Month, Day, Year) MT039190T 17, 1999 30. Name and address of person who dempleted cause of death (Item 23a) (Type, Print) Marc Nutt Baltmire Johns Hoplins Hospital 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State Registrar

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

tal Hygiene

WILSC	N					Sta	ate c	of Mar	yland /	Department	of	Health	and	Men
TEMS .	#23	PART	T	27	28A-F	PFR	MEO	G769	3-8-99	Certificate	0	f Death	2	

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	U	5		0	60	

2. Data of Death

3. Time of Death

Physician	
/Medical	
Examiner	

1. Decedant's Nama (First, Middla, Last)

Funeral Director

Be Completed by Funeral Directo

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at 2008. Baltimore, Maryland 21215-0020

> Physician /Medical **Examiner**

ate hes been signed by the attending physician end page 2 should be deteched for use as the bunel-transit The law requires that the death certificate be executed certificate within 24 hours after death.

To the Funeral Director: After this certified completely filled in by the funeral director, To the Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760,

1 -	Ruby S. Wilson								FEBRUAF	X 6,199	9	094	6 AM
il r	4a Facility Nama (If not institution, giva	street and numbe	er)	ATT TO			b. City, To		cation of Deeth				
	1726 NORTH CALHOUR	N STREET				E	ALTIM	ORE (CITY	N/A			
	5. Social Security Number 6. Se 215-78-2187	X 7./	Age (In yrs. 36	last birthday) Yrs.		ar 1 Yaar B Days	If Under Hours	Min	8. Dete of Birth (Month, Day 11	, Year) , 1962	9. Birthpla Country	ce (State y) MD	a or Foreign
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	James M. Wils	on					Ma	jori	e Col	es			
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	3 ☐ Suicida 6 🖾 Could not be datarminad	28a. Place of I building,				ory, office		2		Street and Numb vn, Steta) 1726 DRE CITY,		Routa N UN S	Umber TREET,
1								-		,	100		

State Registrar

Medical

FEB 2 2 1999 31. Date filed

29a. Certifier (Check only one)

29b. Signature

30. Name and

111 Penn Street, Baltimore, Maryland 21201 2. Registrar's Signature

of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(s) end menner es stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and place, and due to the cause(s) and place and place and place and place are the time.

29c. Licansa number

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29d. Data signed (Month, Day, Year)

FEBRUARY 7, 1999

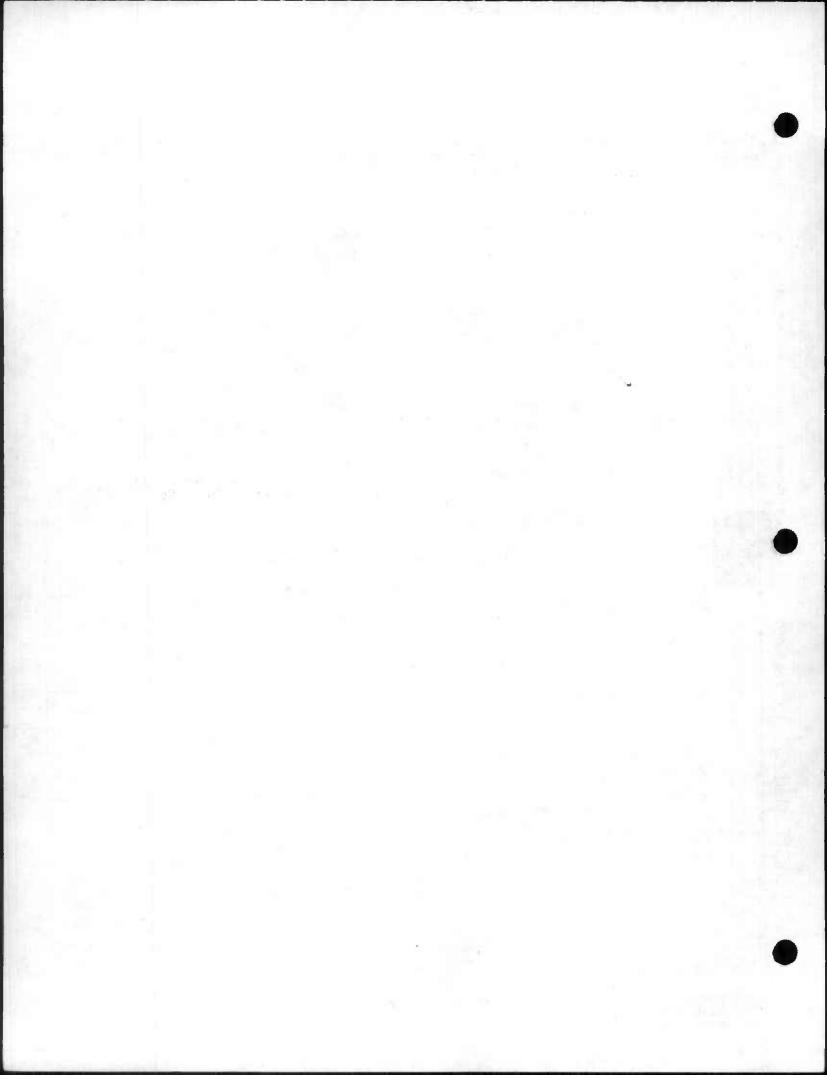
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death **Physician** 1020 am HELEN WRIGHT =e6 1999 19 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** 1□M 2**X**F Director 164-50-4346 Usual Rasidence of Decedent 10h County 10c. City, Town or Location tOd Inside City Limits filed within 72 hours efter death with the Marylan Hygiene. Whenes and Institutels, or flems 23s or 28s4 show ent, the Maries from the notified as Howard 1 Tyas 2 No Columbia Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7080 Cradlerock Way Apt 301 21045 12. Was Decedent Evar in U,S. Armed Forces?

1 ☐ Yas 2 ☒ No If Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specity: Specify: Black à 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working tifa. DO NOT use ratired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker permit. Pages 1 end 2 should be filled wit.
Department of Heelth and Mental Hygient Important: if Nem 27 le marked other that eny injury or other treumatic event, Imag. pages. Own Home 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) 8 Silas Gray Icer French 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Carolyn R. Fleming (Daughter) 11621 Dark Fire Way, Columbia, MD 21044 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 12 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Columbia Memorial Park 2/23/99 Clarksville, MD 21. Signature of Pureral Service License 22. Nama and Addrass of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road, Columbia, MD 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediata Causa (Final Acute Par creatitis diseasa or condition resulting in death) Examiner DCREATIC physicien end the buriei-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last HOLELITHIASIS
Dua to for as a consequence of): Box 68760. Physician/Medical BLE CHOLANGITIS
AND SEPSIS. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Hypertension ACUTE RENAL FAILURE þ 24b. Were autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Completed GLUCOSE INTOLERENCE LEUCOCYTOSi t ☐ Yas 2 ☐ No Division of Vitai To the Mospital or Attending Physicien: "within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p 25. Was case rafarred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 27 No Certification: To 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yas 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the tima, data and place, and dua to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) AD (NARAYANA DIVAKARUNI, M.D. M.D. 19510 Feb 19, 1999 HICKORY RIDGE RO, COLUMBIA, MD 21044 31. Data filed (Month, Day, Year) 32. Registrar's Signatura FEB 22 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Deeth 3. Time of Death Month Dey Year FEBRUAR > 06, 1999 cation of Death 4c. County of Death 0846 Rebecca West 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) ADELPHI PRINCE GEORGES HILLHAVEN INC NURSING CENTER If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) If Under 1 Year Birthplece (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Yaar) Days 1□M 25 F Months 101 216.54.8013 AUG. 1, 1897 MARYLAND 10a State 10b. County 10c. City. Town or Location 10d Inside City Limits 1 Yes 2 No MARYLAND PRINCE GEORGES ADELPHI 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3210 POWDERMILL ROAD 20783 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 ☑ No Specify Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/industry 15. Decedent's Education (Specify only highast grada complated) Elementary/Secondary (0-12) College (1-4or 5+) 5+ TEACHER PUBLIC SCHOOLS 18. Mother's Name (First, Middle, Maiden Sumama) 17. Father's Name (First, Middla, Last) ABRAHAM STEINBACH SARAH WOLFE 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) FRED SCHLESINGER/GREAT NEPHEW 1425 WOODMAN AVE, SILVER SPRING, MARYLAND 20902 20a. Method of Disposition 20b. Place of Disposition (Nama of cematery, crematory or other place) Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3X Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) KING DAVID MEMORIAL GDNS 2.8.99 FALLS CHURCH, 21. Signature of Funeral Service Licensee 22. Name end Address of Facility FBYARROSAGELLEUNERAL RUBECTION; comate commate programme and peach of the pe 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallors. List only one ceuse on each line. Immediete Ceuse (Final disease or condition resulting in deeth) . SUBDURAL HEMATOMA Due to (or es e consequence of) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in deeth) Last Due to (or as a consequence of) Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown CONGESTIVE HEART FAILURE 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy HYPERTENSIVE CARDIOVASCULAR DISEASE 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred CHAIR 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 5 Pending Investigation Injury 35 AM 1 Netural 1 Yes 2 No JANUARY 29, 1999 FOUND 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 Accident ON CONCRETE 6 ☐ Could not be determined 3 ☐ Sulcide

burial-tran pue thet the death certificate be axed

Physician

Examiner

Funeral

Director

7 is marked other than "naturel", or hems 23s or 28s-f show treumstic event, the Medical Examiner must be notified at

other 1

Depertment of Important: If any Injury or 0

Physician /Medical

Examiner

Peges 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Nem 27 is marked other than "naturel", or He

Maryland 21215-0020

Baltimore,

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physician a s the burial use signed by the e pege 2 has certificate this funeral after death.

Division of Vital Records, P.O. Box 68760

Hospital or Attending Physician:

To the Hospital of within 24 hours all To the Funeral D

25. Was cese referred to medical examiner?

1 X Yes 2 No

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STRUCK HEAD

281. Location (Straat and Number or Rurel Route Number, City or Town, State) 3210 POWDER MILL RD. ADELPHI

29a. Certifier (Check only one)

4 Homicide

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as steled.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29c License number

NURSING HOME

29b. Signature end title of certifier

31. Date filled (Month, Day, Year)

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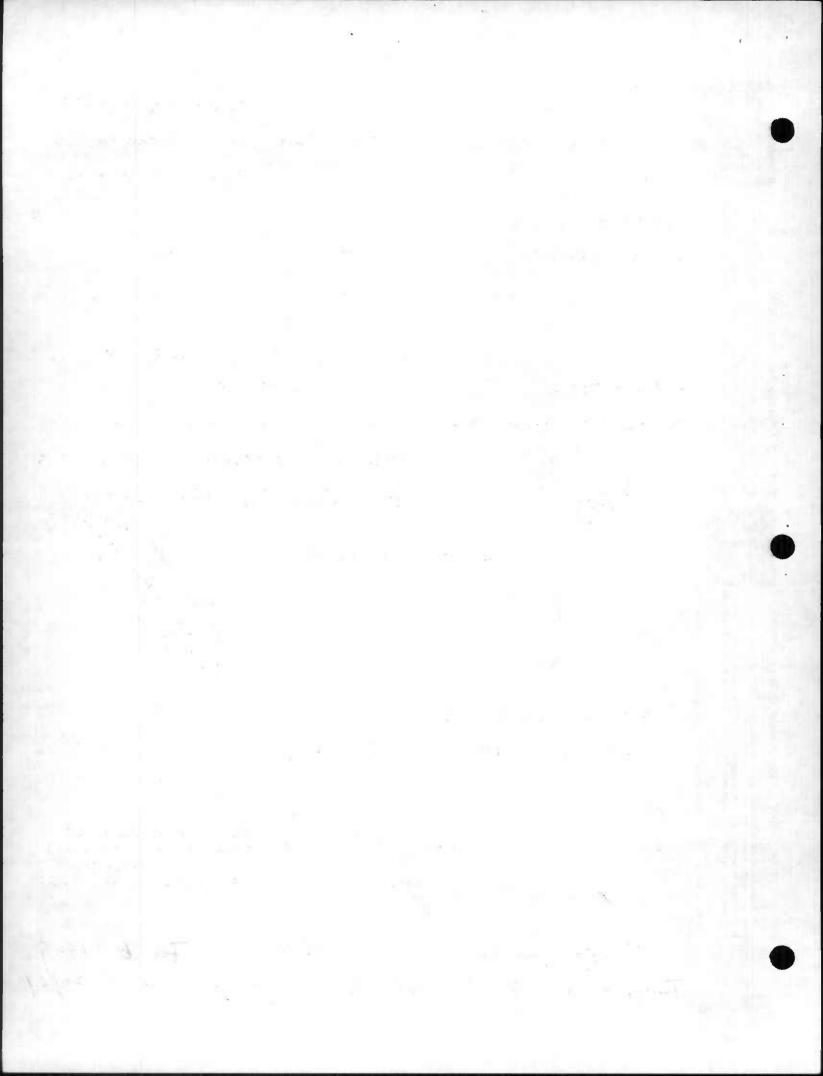
29d. Date signed (Month, Day, Year)

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

State Registrar

completely filled in by

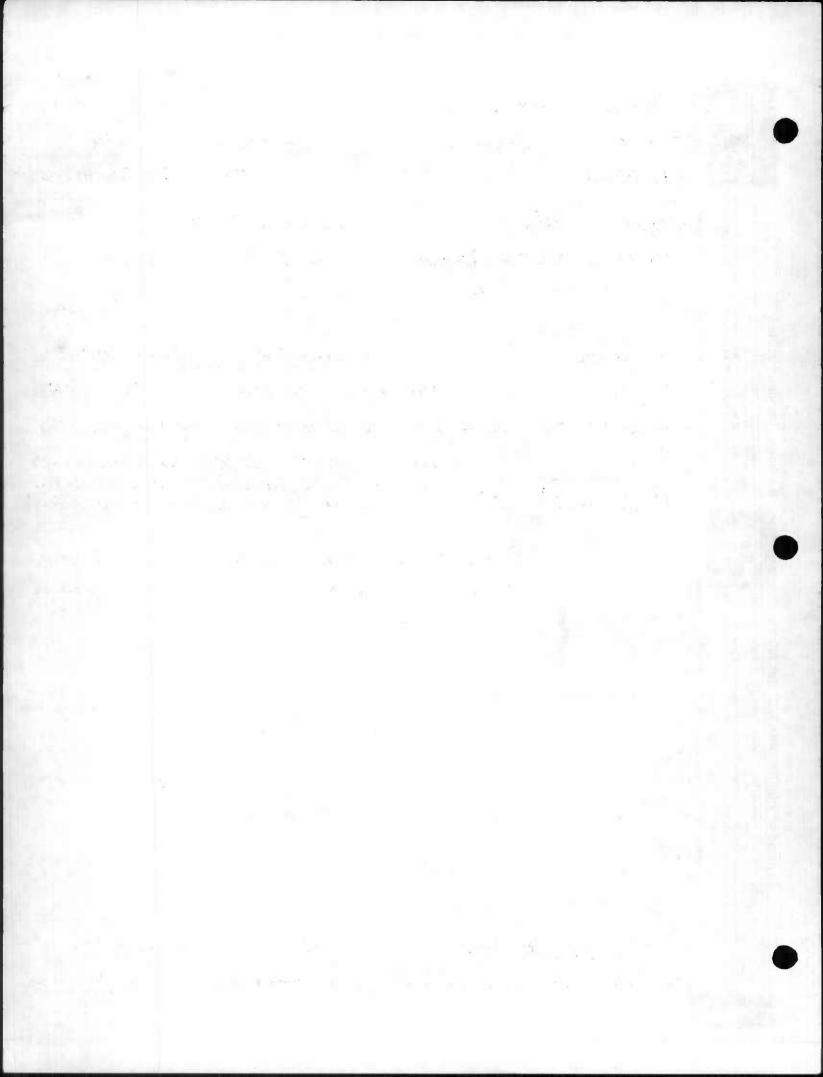
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State of Maryland / Department of Health and Mental Hygiene 9 05135

			Certific	ate of Death	F	leg. No.	UJ	133
Physicia	1. Decedent's Nama (First, Middle, La	Jallace			2. Data of Dea Month	th Day	Yaar .	Tima of Death
/Medica	al reare			Ab City Town o	Tebruar Location of Death			5:59 pm
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Funeral Director		□ M 2 X F	74 Yrs. Month		(Month Day	9,1925	South	+ CAROLINA
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28e	MARVIAND 10e. Street and Number 1826E, NC 11. Marital Status 1 Nevar Marriad 2 Married			Zip Coda		l0g. Citizan of W	/hat Country?	
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me 2	11. Marital Status	12. Was Decadant Evar Armad Forcas?	in U,S. 13. Was De	cedant of Hispanic Origin? (specify Cuban, Maxican, Pue	Specify Yas or No-		- Amarican I	Indian,
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Baltin semit. Pa Separtmer mportant uny injury ance.	21. Signature of Funeral Service Liver		22. Name	and Addrass of Facility	05-21-11	2 CV	19122	S MA
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	23a Part1 Enter the disease or com	plications that caused the	death Do not enter the r	ON, FULTO	NAVE.	ALTIHOA	E, MD.	21217
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O be de ched	Part II. Other significant conditions o	ontributing to death but no	ot rasulting In tha undarlying	ng ceusa givan in Part I.	23b. Dld t			e cause of death?
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(30. Name and address of parson who	complated ceusa of daath	(itam 23a) (Type, Print)	1		_		
	SCOTT ZAFT JUL	is Hopkins Isa	unice Medica	1 Center, 4940	Fastern Al	re Laltin	iore, mo	0 21224
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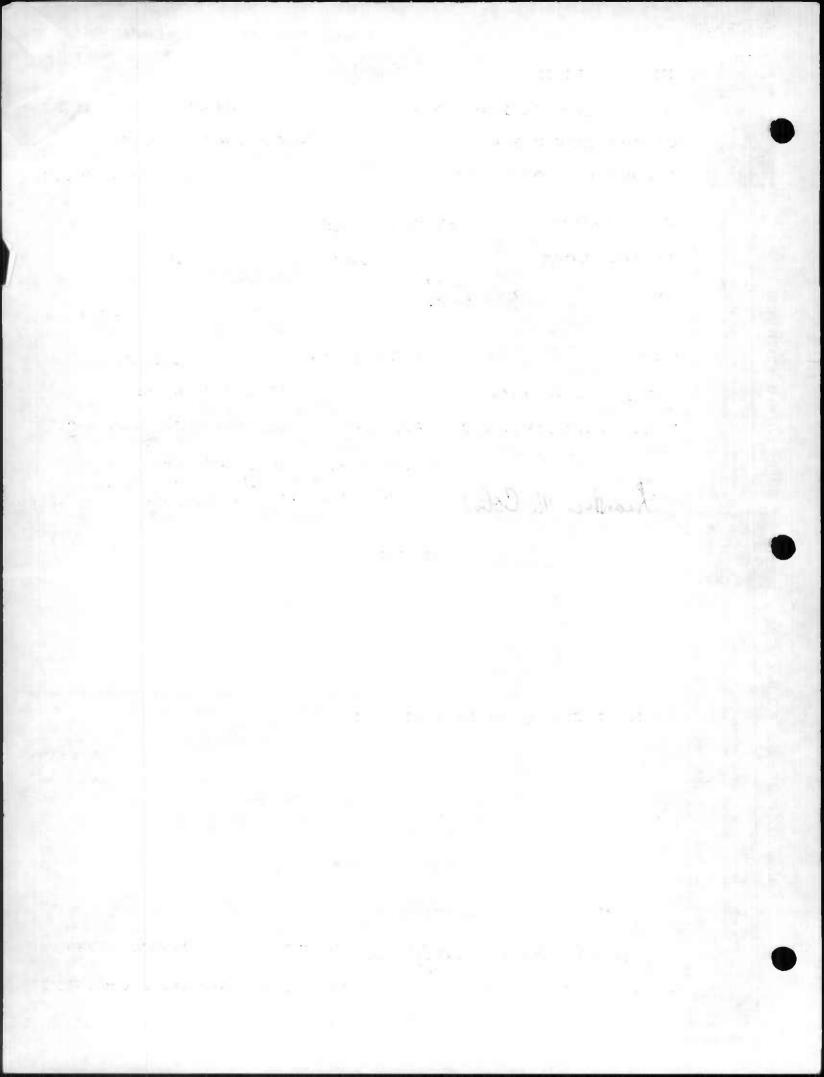


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	Examir		4a Facility Name (If not instituti	ion, give	street end number,)			4	b. City, Town, or L	ocation of Dea	th	4c. County of	Death	
			HARFORD MEMORI	IAL I	HOSPITAL					HAVRE DE			HARFOF		
	Funeral Director		5. Social Security Number 579-50-2415 Usual Residence of Decedent	6. Se:	THE OFF	ge (In yrs.	last birth	Months [Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D JULY	irth ey, Yei 27	1936	9. Birthplace Country) WASH	(Stete or Foreig
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	with t		10e. Street and Number					10f. Zip Co					Citizen of Wh	nat Country	
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020	or its	by Funeral	11. Marital Status 1 Never Married 2 Maried 2 Maried 3 Widowed 4 Divorce	arried	12. Was Decedent Armed Forces' 1 ∰ Yes 2 ☐ If Yes, Give Year or Dates:	No		If Yes, specify		ispanic Origin? (Sp n, Mexicen, Puerto Specify:	Rican, etc.)	0-		White, etc.	
5-0020	72 hours		15. Decede	ent's Edu	cetion		16a. D	ecedent's Usual C	Occup	ation	1	16b	. Kind of Bus	BLAC iness/Indust	
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Maryland	should be ad Mental marked o	10	ROBERT J. WA	SHI	NGTON					ELSIE R	EGINA	DO	RSEY		
a	2 sho		19a. Informant's Name/Relation	nship (Ty	rpe, Print)		19b. N	Mailing Address (S	Street	end Number or Rui	al Route Numi	ber, Cit	ty or Town, S	tete, Zip Co	de)
	に回ると		ELSIE WASHIN	GTO	N MOTHE			01 14th		T N.W.	WASHI	T			
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alt	permit. Pe Department Important any Injury		21. Signature of Funeral Service	e Licens	99			22. Name and			14 up:	shu	r ST.	N.W	
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ч	Physician		SHOOK, OF HOUSE FAILURG. LE	at only of	10 00030 011 00011	mio.									set and Death
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	Examiner		resulting in death)	-	3	Due to (o	or es e co	nsequence of):						1	
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Box		any			d	-								1	
	0 00	sici	Part II. Other significant condit	tions cor	ntributing to death t	but not res	ulting in t	he underlying cau	ıse giv	en in Part I.	23b. Dla	tobac	co use cont	ribute to th	e cause of death
, P.O	that the sed by detac	by Physician/Medical	CHRONIC OBSTRUCT	IVE P	ULMONARY D	ISEASE	SCHI	ZOPHRENIA			10	Yes	2□ No :	3 Probab	ly 42 Unknow
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R	9 4 8	EO									159	Yes	2□No	1,2X,Y	es 2 No
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Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attence completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Coul-	d not be mined	28e. Place of In building, e	ijury - At ho tc. (Specif	ome, fam	n, street, factory, o	office		28f. Location City or To			r or Rure! R	oute Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical C	29a. Certifier (Check only one) 1 Certify Madica	ing Phys il Exami	sicien: To the best ner: On the basis of and manner si	of examina	wledge, o	death occurred at or investigation, in	the tin	ne, date and place, pinion, death occur	and due to the red et the time	e cause , date	e(s) and man and place, ar	ner as state nd due to the	d. e cause(s)
	within To the comple	Me	29b. Signature and title of certif	ier				29c. L	Licens	e number		29d.	Date signed	(Month, Day	r, Year)
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State Registrar

Radentz,
32. Registrar's Signature Stephen S.
31. Date filed (Month, Day, Year)

30. Name and address of person who completed ceuse of deeth (Item 25e) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201



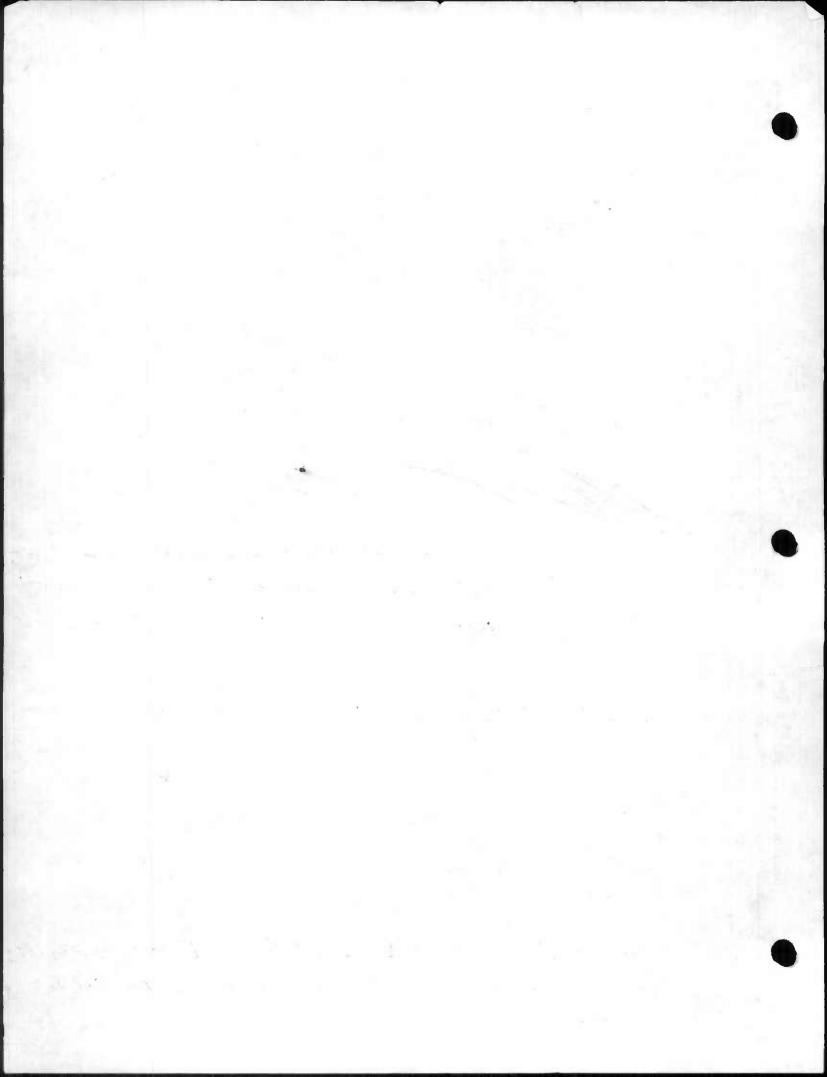
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician TERRY DUANE ZAHREN FEBRUARY 21, 1999 3:10 A.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5036 HILLTOP ACRES ROAD PERRY HALL BALTIMORE If Under 1 Year 5. Social Security Number 6. Sex If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 150 M 2 D F Months Hours Director 481-60-8354 IOWA Usual Residence of Deceden permit. Pages 1 and 2 should be filled within 72 hours effer deeth with the Marylan Department of Health and Mentel Hygiena. Important: if Item 27 is marked other than "natural", or flerns 23s or 28s-f show early fujury or other traumatic event, the Medical Examination at be northed at bods. 10n. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director MD BALTIMORE PERRY HALL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21128 5036 HILLTOP ACRES ROAD USA 14. Race - American Indian. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Detes: Bleck, White, etc. 1 Never Married 2 Merried altimore. Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry MD STATE TEACHER College (1-4or 5+) Elementary/Secondary (0-12) ASSOC. UNION REPRESENTATIVE 17 Father's Name /First Middle (ast) 's Name (First, Middle, Maiden Surname) 8 CHARLES ZAHREN DARLENE BRAUNSCHWEIG 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) JUDITH ZAHREN WIFE 5036 HILLTOP ACRES ROAD PERRY HALL, MD 21128 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 2/22/99 METRO CREMATORY, INC. CATONSVILLE, MD 21. Signature of Funeral Sergice License 22. Name end Address of Facility THE JOHNSON FUNERAL HOME, P.A. an or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory. List only one cause on each line. Approximete
Interval Between
Onset and Death TOWSON, MD Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physicien and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last P.O. Box 68760, Physician/Medical Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Records. à 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No of Vital Hoapital or Attending Physician:
 At hours after death.
 Funeral Director: After this certificatily filled in by the funeral director, 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division 1 Natural
2 Accident 5 Pending 1 Yes 2 No 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completary filled in Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated. 29b. Signature and/title of certifier mon who completed cause of death (Item 23a) (Type, Print) Blud Kaven toward nev 5601 32. Registrer's Signature State

Registrar **DHMH 16 Rev 6/95**

1999

FEB 22



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death Month 6:08Am Mary Jean Antrim Feb. 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Harford Mariner Health of Bel Air Bel Air 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthdey) Birthpleca (State or Foreign Country) 1□M 20 F Deys 89 Yrs. 218-34-6755 June 24, 1909 Indiana Usuei Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1√ Yes 2 No Harford Maryland Bel Air 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 410 East McPhail Road 21014 USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Stetus 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detas: 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 ☐ No Specify: Specify: White 3₺ Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) Homemaker Own Home 4 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Russell Charles Packard Mae (NMN) Harrison 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Julia A. Laylon/Daughter 203 Bucket Post Court, Bel Air, MD 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Hilltop Service Corp. 2/4/99 4 □ Donetion 5 □ Other (Specify) Towson, Maryland 22. Name end Address of Fecility Howard K. McComas III Funeral Home, P.A. bese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or reepiratory errest, approximation. Approximate Intervei Between Onset end Deeth Immediate Causa (Final severe ADRICC STUDGIS diseese or condition rasulting in daeth) Due to (or as a consequence of) Dua to (or as e consequence of): Due to (or es e consequenca of):

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item 27 is marked other than "natural", or items 23s or 28s-f show other traumetic event, the Modical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Deportment of Heelth and Mental Hygiene. Important: If Itam 27 ia marked other than "naturel", or ther eny Injury or other traumetic event, the Medical Exercises.

Baltimore, Maryland 21215-0020

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Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Congetiu

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

26. Pieca of Death (Check only one)

24b. Were eutopsy findings evallable prior to completion of cause of daath? 24e. Wes en autopsy performed?

1 ☐ Yes 2 ☐ No

25. Wes case raferred to medical 1 Yes 2 No

27. Menner of Death

1 Naturet

2 Accident

3 Suicide

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of tnjury (Month, Dey Year)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 42 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how Injury occurred

 Piece of Injury - At homa, farm, street, fectory, offica building, etc. (Specify) 4 Homicide 29e. Certifier

Location (Street end Number or Rural Route Number, City or Town, Stete)

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(Check only one) 29b. Signature end title of certifier

1. Certifying Physician: To the best of my knowledge, deeth occurred et the time, data and place, and due to the ceuse(s) end mennar es stated.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, daath occurred et the time, date end pleca, end due to the cause(s) end manner steted. 29c. License number

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed muse of death (item 23a) (Type, Print)

State Registrar

31. Dete filed (Month, Day, Year) FEB 3

5 Pending

Investigetion

6 Could not be determined

32. Ragistar's Signeture



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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** KOBERT 630An AUSTIN 21 Jan /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner UNIVERSITY OF MARYLAND None 5. Social Security Number If Under 1 Year Birthplaca (Stata or Foraign Country) 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) Months 1[3M 2□ F Yrs. 131-24-8211 65 Mar 10, New York Usual Rasidence of Decedent 10a. Stata 10c. City, Town or Location 10b. County 10d. Insida City Limits 1 ☐ Yas 2 No Directo Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10005 Hackberry Lane 21046 United States Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) Race - Amarican Indian, Black, White, atc. 12. Was Decedent Evar in U,S Armed Forces? 11. Marital Status 1 XYas 2 No If Yas, Giva Year or Datas: Korean 1 Never Married 2 Married 1 Yas 2 No Specify: Specify: 2 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Attorney Insurance 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be Robert W. Austin Sr. Gabriella Connelly 19a. Informant's Name/Ratationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Nina Austin/Wife 10005 Hackberry Lane Columbia, Maryland 21046 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from Stata Good Shepherd Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 1-25-99 Ellicott City, MD 22. Nama and Addrass of Facility Harry H. Witzke's Family Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata tritarval Batween Onset and Death Immediate Causa (Final disease or condition rasulting In death) · ACUTE PANA PAILURE Examiner SHOCK PNEUMONIA Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown by Completed Be 2

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item 27 is marked other than "natural", or itema 23a or 28a-f show other trsumatic event, my Marical Examinar must be notified at

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permit. Pages 1 and 2 should be fill Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0020

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death

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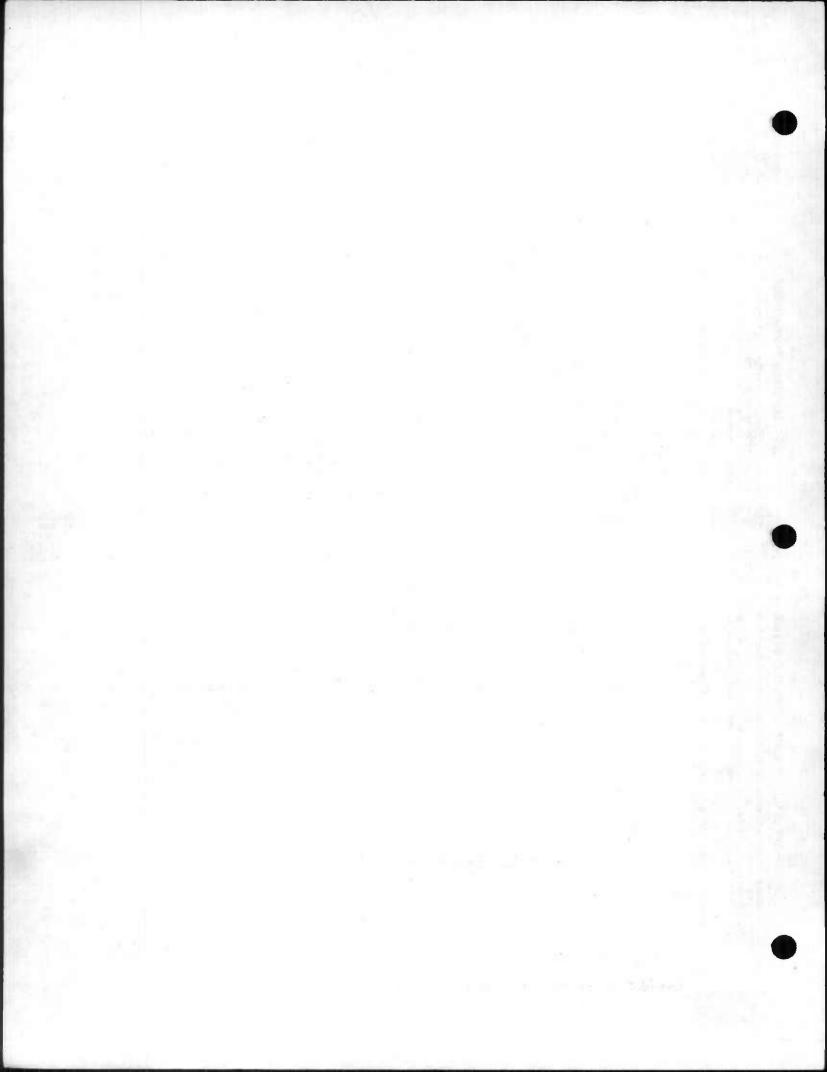
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completed causa of death (Item 23a) (Type, Print)

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29c. Licensa number

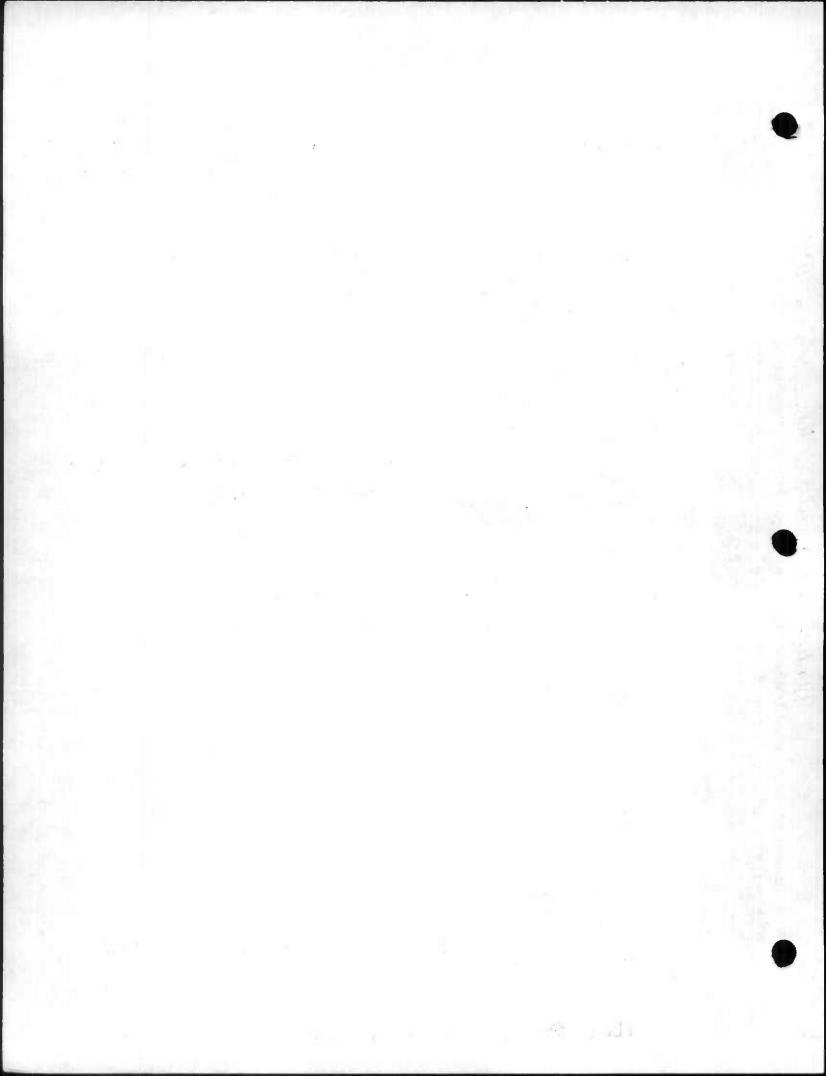
29d. Data signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Yaar **Physician** Month 11:40 AM Gladys Corinne Blattner February 3, 1999 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year 8. Data of Birth (Month, Day, Year) May 23, 1903 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country)
 New York **Funeral** Days Months Hours 1□ M 2⊠ F 95 Yrs. Director 212-48-6830 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Insida City Limits MD 1 Tyas 2 X No Harford Aberdeen 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Dir 819 Matthews Avenue 21001 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Biack, Whita, atc. 1 ☐ Yas 2 ☑ No If Yas, Giva 1 Nevar Married 2 Merried 1 ☐ Yas 2 No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In home 11 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Surname) 88 8 Montal Udel Drake Jennie Gustafson Pages 1 and 2 should Health and 19a. Informant's Name/Relationship (Type, Print) 19b. Maiting Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Department of Hear Important: If Item 27 is important: or other try Barbara Blattner (Daughter-in-law) 819 Matthews Ave., Aberdeen, MD 21001 Baltimore, 20b. Place of Disposition (Nama of cematary, crematory or other plece) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata Burial 2 Cremetion 3 Removel from State Dulaney Valley Mem. Gdns. 2/8/99 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungral Service Licenses 22. Nama and Addrass of Facility Tarring-Cargo Funeral Home, P. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that cannot the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a prince. Approximata Intarval Batween Onset and Death **Physician** Immediata Causa (Finat disaasa or condition resulting in death) /Medical **Examiner** Dua to (or as a consequenca of): The lew requires that the deeth certificate be executed burial-trans Sequentially list conditions, if any, teading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last ereprovancu Physician/Medical Dua to (or as a consequence of) USB BS Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? is certificate has been signed by director, page 2 should be detac 1 Yes 2 No 3 Probably 4 Unknown Records, ð Completed 24b. Wara autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1 Yas 2 No 1 Yas 2 No of Vital Attending Physician: 25. Was casa referred to medical axaminar? Be 26. Placa of Death (Chack only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yas 2 10 this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred After Division 5 Pending invastigation 1 DNatural I or Attendin after deeth. Director: Aft 1 Yas 2 No 2 Accident illed in by the 3 Suicide 6 Could not be 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.

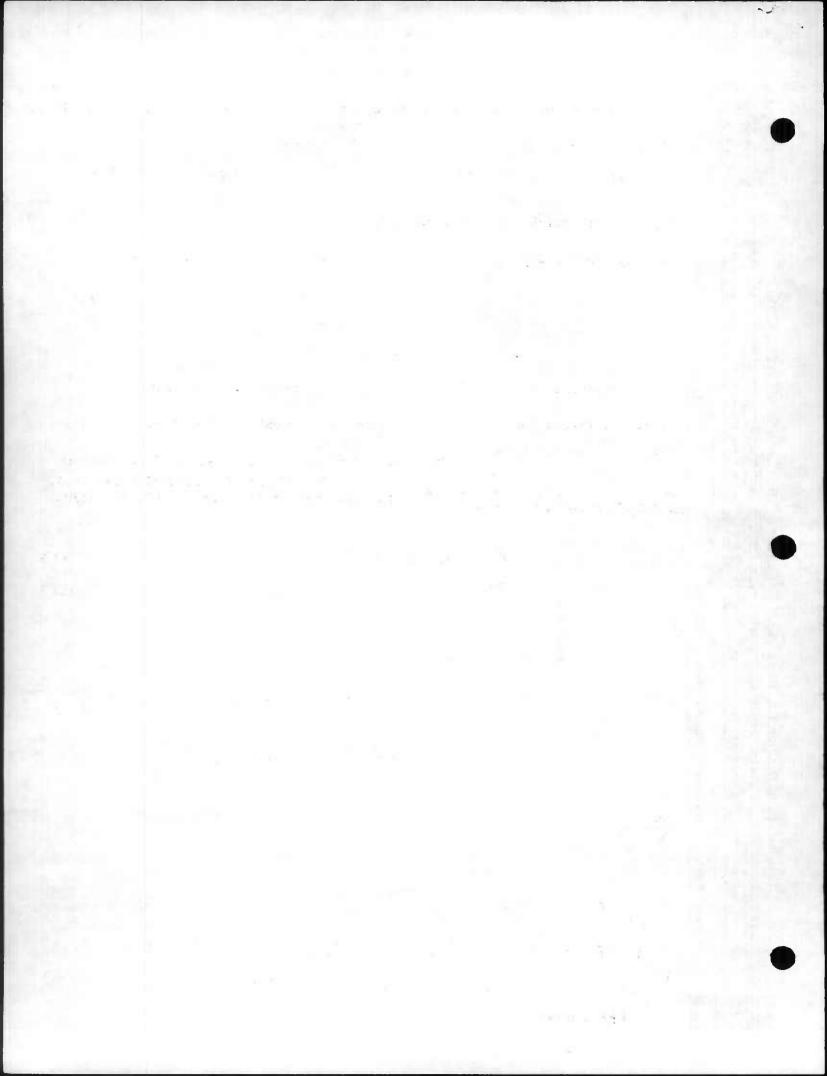
| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) To the vithin 2 29b. Signatura and titla of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) M.D (mion) 30. Nama and addi at of p who completed causa of death (Item 23a) (Type, Print) ESTHER OPINION 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State Registrar **DHMH 16 Rev 6/95**

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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		1□M 2XF 68	Yrs.	Months Deys	Hours Min.	8. Date of Bir (Month, Di Aug.]	2, 1930	Fran	e (State or Fore) C.e.
t	Usual Residence of Decedent						, , , ,		
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	Maryland Frederi	ick	Frederic	ck					1X Yes 2
חופרוסו	10e. Street and Number			10f. Zip Code			10g. Citizen of W	Whet Country	7
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	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give		1□ Yes 2₩ No	Specify:		Specity	Whi	te
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	Francois	Pe	etite		Helene	Louvin	e Perri	naux	
-	19a. Informent's Name/Reletionship	(Type, Print)	19b. Mait	ting Address (Stree	at and Number or Rui	ral Route Numb	er, Cify or Town,	Stete, Zip Co	ode)
	Patrick T. Byrne	, son	139	Ardenlee	Peachtr	ee City	, Georgi	ia 30	269
	20e. Method of Disposition		20b. Place of Disp cemetery, cre	position (Name of emetory or other pla	ace)	Dete	20c. Location -	City or Town	, Stete
l	1XXBurial 2 ☐ Cremation 3 € 4 ☐ Donetion 5 ☐ Other (Speci		Willame	tte Natio	nal	2-11-99	Portland	d, Ore	gon
-	21. Signeture of Funeral Service Ligar	inent .	2	22. Name end Addr	ess of Fecility Sta	uffer 1	Tuneral H	Homes,	P.A.
	12.1.1	Ontario			sumtown Pi				1702
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		dcontributing to death but n	ot resulting In the	underlying cause g	iven in Pert I.	10	Yee 2 No	3 ☐ Probat	eutopsy findin
		dcontributing to death but n	iot resulting In the	underlying ceuse g	iven in Pert I.	1 = 24e. Wes		3 Probat	eutopsy finding ble prior to bietion of cause
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Agnes Matilda Blocher February 15, 1999 12:45 A.M. 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Gladys Spellman Nursing Home Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) 10 M 20 F 220 26.9556B Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince George's Maryland Greenbelt ₩ Yes 2 No 10g. Citizen of Whet Country? United States 10e. Street end Number 10f. Zip Code 141 West Way Road, Apartment 103 20770 of America Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, Bleck, White, etc. 11 Marital Status 1 Never Merried 2 Merried 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Yes 2 No Specify: Specify: 3 X Widowed 4 □ Divorced White 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Restaurant Waitress 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme), 1. ... Archie Hott Edith Stevenson 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 141 West Way Road, #103, Greenbelt, Maryland 20770 Lillian Chiles/ Daughter 20b. Placa of Disposition (Neme of cametery, cremetory or other place) Cemetery February Garrett Coun 20e. Method of Disposition 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Garrett County, Emmanuel United Methodist 20,1999 4 ☐ Donetion 5 ☐ Other (Specify) Maryland 21. Sign in e of Funerei Service Licansee 22. Name and Address of Fecility Sowers Funeral Home

Physician /Medical **Examiner**

any Injury or

Physician

/Medical

Examiner

10a. Stete

Funeral

Director

Show

r than "natural", or items 23a or 28a-f ahov the Medical Examiner must be notified at

Directo

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours efter

Hygiene.

Department of Health and Mental Hygic Important: If Item 27 is marked other

altimore, Maryland 21215-0020

The law requires that the death certificete be executed

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner and the burial-tran attending physician use as signed by the a þ After this certificate hes been situated the second function of the second seco Be Completed To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, to 9 Medical Certification:

23a. Pert1. Enter the disease, or complishock, or heart feilure. List only or Immediate Cause (Finel disease or condition resulting in deeth)	Arterios	th. Do not enter the	mode of			spiretory errest,	seg	50	Onset	ximete el Between end Death
	Due to (c	or es e consequence	of):					1		
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Per II. Other significant conditions con Cerebral 1. Dyshhafia			ng cause	e given In Pert I.	_		2□ No	3 □ Pro	Vere euto	4 Unknow
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29c. License number

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29d. Dete signed (Month, Dey, Year)

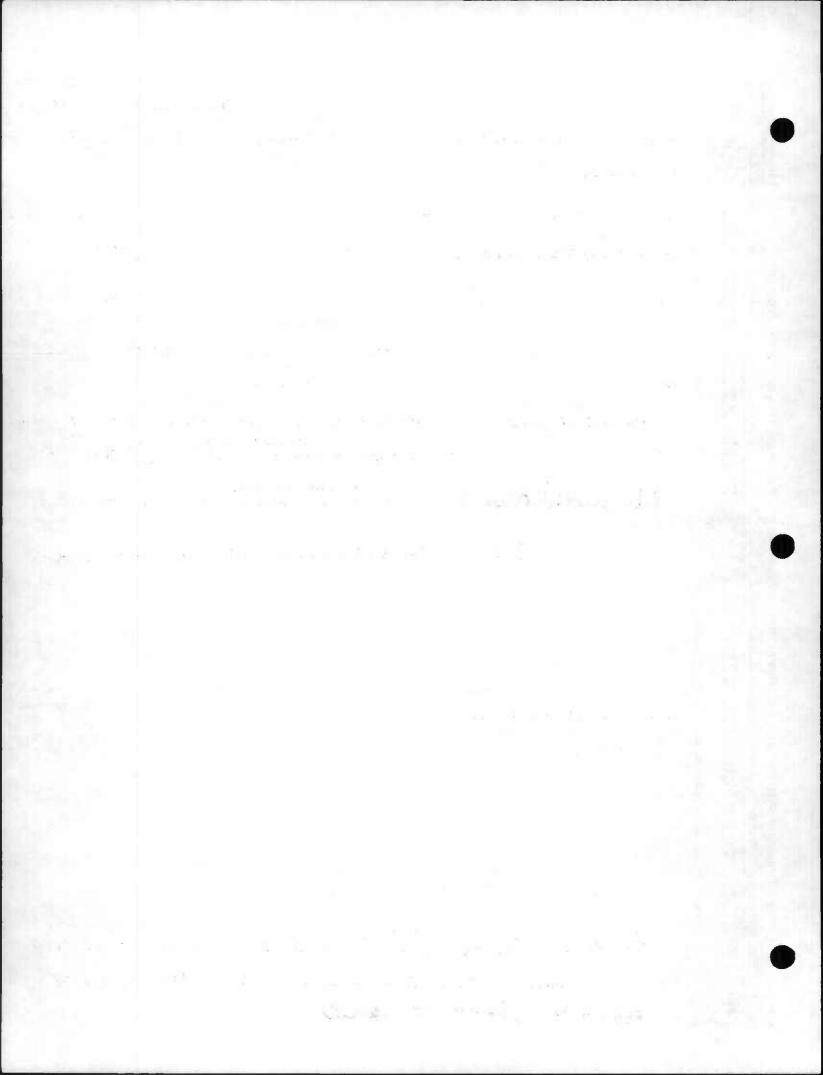
FEBRUARY 15 1999

State Registrar 31. Dete filed (Month, Day, Year) FEB 1 8 1999

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

29b. Signeture end title of cartifier

DEVORE MD 4203 Queenstung Rd Huattsuille Manyland 2078, 32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Amended #5, 2/4/99, L.A.P., O.A.Co. 3. Tima of Deeth 1. Decedent's Name (First, Middle, Last) 2. Data of Deeth Month Day Year **Physician** Casper William Barlow 21, 195 4c. County of Death 5:30PM Jan. /Medical 4e Fecility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Death Examiner 220 N. Commerce Street Centreville Oueen Anne's If Under 1 Year If Under 24 Hrs. 8. Dete of Birth
Months Deys Hours Min. (Month, Dey, Year) 5 Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stete or Foreign Country) **Funeral** 112 M 2□ F Months 227-36-3364 Usuar Residence of Decedent 49 Director Apr. 11, 1949 North Carolin the Maryland 10c City Town or Location 10d Inside City Limits 10a State 10h County Show "natural", or items 23s or 26s-f sho Md. Oueen Anne's Centreville MXes 2□No Director 10g. Citizen of What Country? 10e. Street end Numbe 10f. Zip Code with 21617 U.S.A. Commerce Street 220 N. death Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Dacedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. d 2 should be filed within 72 hours after of the and Mental Hygiene.
7 Is marked other than "natural", or iter traumatic event, the Medical Exertives. 1 Pyes 2 No If Yes, Give a ft Year or Dates: 1 Never Merried Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade complated) Self employed Elementery/Secondary (0-12) College (1-4or 5+) Cable TV Installat Cable TV installation 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be a Neva Chloe Lewis Owen Stanley Barlow 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Wife Health a 220 N. Commerce St., Centreville, Md. Elizabeth K. Henry Item 2 30g Location - City or Town, State 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Jan. 1 ☐ Buriel 2 ☐ Separation 3 ☐ Ramoval from Stele
4 ☐ Donetlon 5 ☐ Other (Spacify) permit. Page Department of Important: if any Injury or once. = 5 Stevensville, Md. Chesapeake Cremation Center, 22. Name and Address of Fecilit 21. Signeture of Funerel Service Livenii Fellows, Helfenbein & Newnam Funeral Home 408 S. Liberty St., Centreville, Md. Enter disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or a failure. List only one cause on a mathematical base of the deeth. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel METASTATIC MELANOMA disease or condition resulting in deeth) Examiner Dua to (or es e consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequence of) attending pl Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributs to the causs of death? the signed by the 1 Yss 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings aveileble prior to completion of cause of death? should Completed 24e. Wes en eutopsy performed? certificata has l 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 24 hours aftar death. Funeral Director: After this certifica stely filled in by the funeral director, I 25. Wes cese refarred to medical Be 26. Plece of Deeth (Check only one) axaminar? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Besidence 6 Other (Specify) 0 1 Yas 2 No 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Pending invastigation 1 Naturel Injury 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide A 24 hour. the Funeral Directory To the Hospi within 24 hou To the Funer completely fil Medical 29a. Certifier 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

State Registrar

31. Dete filed (Month, Dey, Year)

29b. Signeture and title of certifier

32. Registrer's Signeture

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

JAN 2 5 1999

Sparke

Eric Ciganek M.D.; 2540 Centreville Rd., Centreville, Md. 21617

29c. License number

29d. Date signed (Mghth, Day, Year)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended #5, 2/5/99, L.A.P., O.A.Co. Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dev Year 28 1999 Jan 9:50PM Gayle Rita Bramble 4c. County of Death 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Talbot The Memorial Hospital Easton 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) 1DM 2NF Months Days Hours 215-42-7848 Yrs. 55 Nov. 7, 1943 Maryland Usual Residence of Deceden 10c. City, Town or Location 10a State 10b. County 10d Insida City Limits 1 ☐ Yas 2 ☐ No MD Queen Anne's Stevensville 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 512 Talbot Road 21666 U.S.A. 14. Race - American Indian, 12. Was Dacedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 11. Marital Status Black, Whita, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Nevar Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) College (1-4or 5+) Elementery/Secondary (0-12) Administrative Assistant School System 18. Mother's Name (First, Middla, Maiden Sumeme) 17. Fathar's Name (First, Middla, Last) William Jones Lucy M. Daily 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Henry William Bramble - Husband 512 Talbot Road, Stevensville, MD 20c Location - City or Town, Stata Date 31, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Jan. 1 Burial 2 X Cremation 3 Removal from Stata 4 Donation 5 Other (Specify) Chesapeake Cremation Ctr. LLC. Stevensville, MD a Bone 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 106 Shamrock Road, Chester, MD 21619 23a. Part1. Enter the disease, or complication; that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Daath Immediate Cause (Final disease or condition resulting In death) Small + large Bowel in - (va Due to (or as a consequence of): 23b. Did tobacco use contributa to the causa of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part f. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of ceuse of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 28. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Examiner physician end s the buriel-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events rasulting in death) Last Physician/Medical 80

Physician

/Medical

Director

Funeral

þ

Completed

Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumstic event, the Modical Examiner mant be not fired at

permit. Pages 1 and 2 should be filed within 72 l Deperment of Heelth and Mentel Hyglene. Important: If item 27 is marked other than "natu any Injury or other traumetic event, trailed page.

Physician /Medical

Examiner

that the death certificate be executed

The law requires

Attending Physician:

use

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signed b

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certificate

After this funerel

To the Hospital or Attendir within 24 hours after deeth.
To the Funeral Director: Al completely filled in by the fu

deeth.

by

Completed

Be

2

Certification:

edical

Box 68760

P.O.

Division of Vital Records,

the Marylend

With

death

72 hours efter

Brambl

Gayle

Maryland 21215-0020

altimore,

1 Yes 2 No 27. Manner of Deeth

28e. Date of Injury (Month, Dev Year) 5 Pending investigation

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

29a. Certifier (Check only one)

1 Neturel

2 Accident

4 Homicide

3 Suicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the besis of examination end/or investigetion, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and the of partifiar

29c. Licansa number

29d. Date signad (Month, Dey, Year) 9/29 2

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print)

David Smith, M.D., 501 Idlewild Avenue, Easton, MD 21601

State Registrar 31. Dete filed (Month, Dey, Year) FEB 01

6 Could not be determined



Physician

- /Medical

TORINO ROBLEDO BOLANOS

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Cartificate	of	Doath	

2. Dete of Deeth

FEBRUARY 7,

Month

Year

U.S.A.

14. Raca - American Indien, Black, White, etc.

Construction

Hispanic

1999

4c. County of Deeth

HOWARD

Specify:

3. Time of Deeth

4:45P.M.

10d. Inside City Limits

Approximete interval Between Onset and Death

24b. Were autopsy findings eveileble prior to

completion of cause of death?

1 Pres 2 No

1 Yes 2 No

Birthplace (Stete or Foreign Country)

Mexico

4b. City, Town, or Location of Death 4a Facility Neme (If not Institution, give street and number) Examiner RT.95 & RT.175 **JESSUP** If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dev. Year) **Funeral** Months Days Hours 1 M 2□ F NONE 42 Yes Apr 26, 1956 Director Usual Residence of Decedent 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Maryland **Baltimore** Directo Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21221 1505 Alconbury Road Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2□No Specify: Mexican à 3 ☐ Widowed 4 ☐ Divorced Yeer or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Worker UNK UNK 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be 2 should be and Mental is marked Bascilio Robledo Agripina Bolanos 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Nem 27 is m 1505 Alconbury Road Baltimore, Maryland 21221 Joyce Duncan Friend 20b. Place of Disposition (Name of cemetery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, Stete 6 1 Burlal 2 □ Cremation 3 Removal from Stete 02/15/99 Sabinas, Nuevo Leon, Mexico Sabinas Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licansee 22. Name end Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 'n M00535 Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner the ettending physician and hed for use as the buriel-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last Due to (or as e consequence of): Box 68760, Physician/Medicai Due to (or es e consequença of): 23b. Did tobacco use contribute to the cause of death? Records. P.O. should be deteched Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 1 Yas 2 No 3 Probably 4 Unknown by 24a. Was an autopsy performed? Completed peen certificate hes 1 Pres Division of Vital 25. Was case referred to medical examiner? uneral director, Be 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 NOther (Specify) SCENE 10 1 XYes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA After this 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of Injury 28c. Injury et Work? Certification: Date of Injury (Month, Day Year) 5 Pending investigation 1 ☐ Naturel 1 Yes 2 No driver in motor vehicle collition 2/7/99 death. 2 DAccident 1603 after death the 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) R+195@ 175 3 ☐ Sulcide à 4 Homicide To the Hospital o within 24 hours at To the Funeral D street Howard Co, MD 1 Cartifying Phyaician: To the best of my knowledge, deeth occurred et the time, date and piece, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) and manner stated. edical 29a. Certifier (Check only one) 29c; License number 29b. Signature and title of certifie O.C.M.E. 15 M

Torivio Robledo-Bolanos

29d. Dete signed (Month, Dey, Year) FEBRUARY 8, 1999

111 Penn Street, Baltimore, Maryland 21201

2 No

10

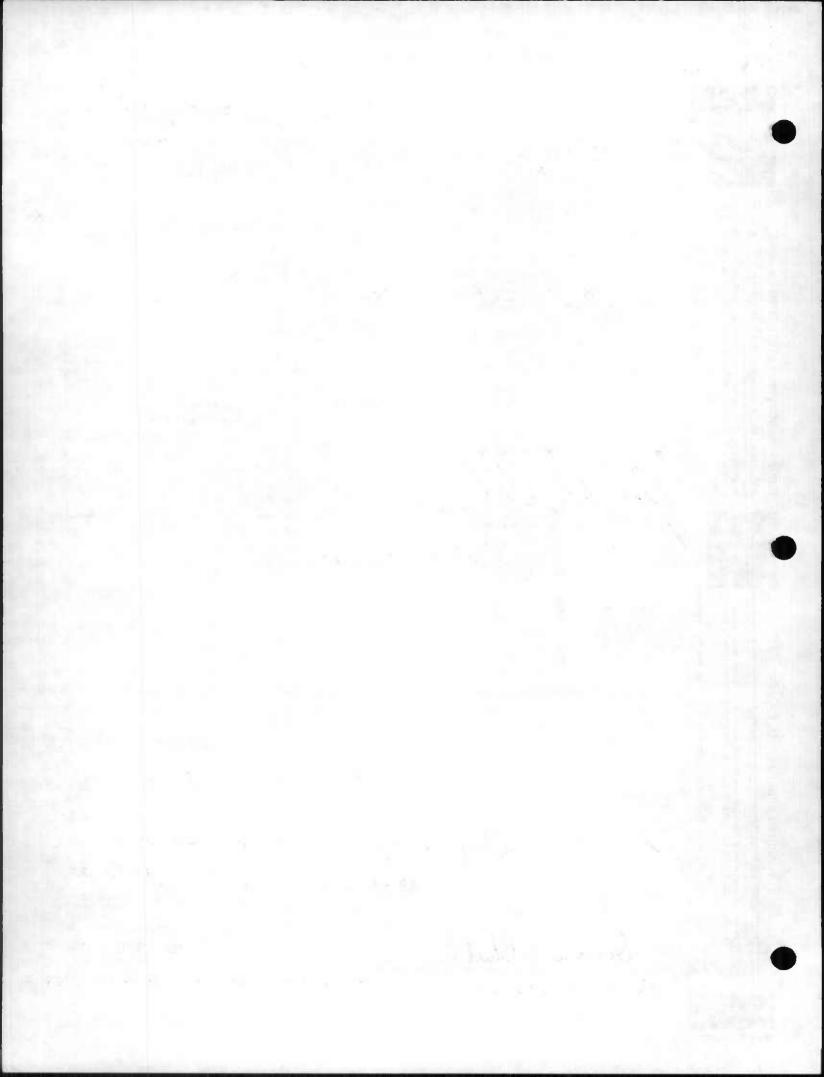
State Registrar

Jennis 31. Date filed (Month, Dey, Year) 1999 FEB 09

30. Name and eddress of person who

MD 32. Registrar's Signature

d cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 10, 1999 **Physician** 9:03 PM Boone Danie February /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not Institution, give street and number) 4c. County of Deeth **Examiner** Regional Hospital Prince Laure George 5 Laurel If Under 24 Hrs. No. 1 B. Dete of Birth (Month, Day, Year) Sep. 30, 1926 If Under 1 Year Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** XX 2DF Months Deys Yrs Director 247-30-3643 South Carolina Usuel Residence of Decedent the Marylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health end Mental Hygiene. Important: if Item 27 is merked other than "naturel", or items 23s or 28s-f show any Injury or other traumetic event, the Modical Examines must be not the date. Md. Howard Savage 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 8801 Lincoln Street 20763 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1944

1XX es 2 □ No
If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. Bleck, White, etc. 1 Never Married 20 Merried altimore, Maryland 21215-0020 1 ☐ Yes 21/21XNo Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Grade Sheet metal polisher Sheet metal Co. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Filymon Firns Ernest Boone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Dorothy A. Boone spouse 8867 Washington Street Savage, Maryland 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Feb 13, Burlel 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Ft. Lincoln Cemetery 1999 any Injury Brentwood, Maryland 21. Signature of Funerel Service Licensee 22. Neme end Address of Fecility Donaldson Funeral Home, P.A. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or healthailure. List only one cause on each line. Laurel, Maryland 20707 Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner attending physician and for use as the buriel-trensit that the death certificete be executed Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest (or as a consequence of): Box 68760. Physician/Medicai Due to (or as a consequence of): 98 23b. Did tobacco use contributs to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Onknown signed to Division of Vital Records. þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? page 2 has 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: funeral director, 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 12 Inpatient Lo 2 ER/Outpetient 3 DOA After this 28e. Dete of injury (Month, Day Year) 28d. Describe how Injury occurred 27. Menper of Deeth 28b. Time of Certification: 28c. Injury at Work? 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No r death. investigation 2 Accident efter death Director: 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital within 24 hours Medical 29a. Certifier 🜠 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. completely 2 Madical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) and menner steled. (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10+1

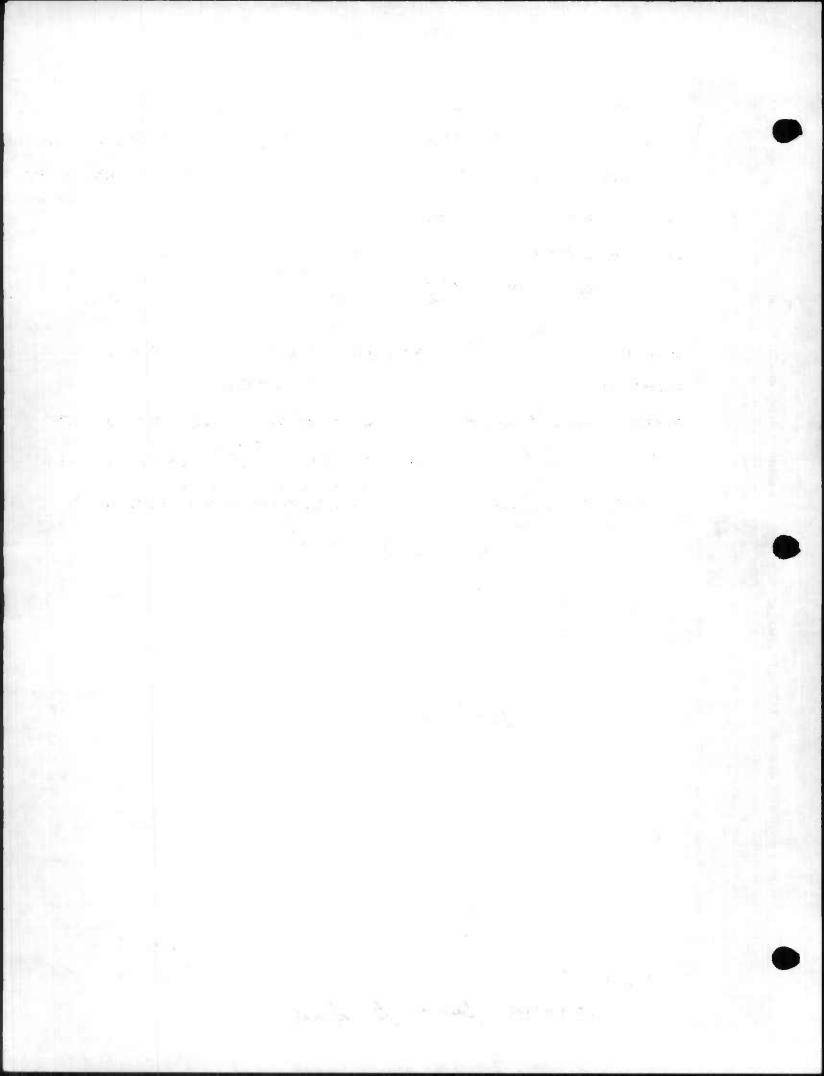
no completed cause of death (Item 23e) (Type, Print)

32. Registra s Signeture

imore Ave

State Registrar 31. Date filed Month, Day,

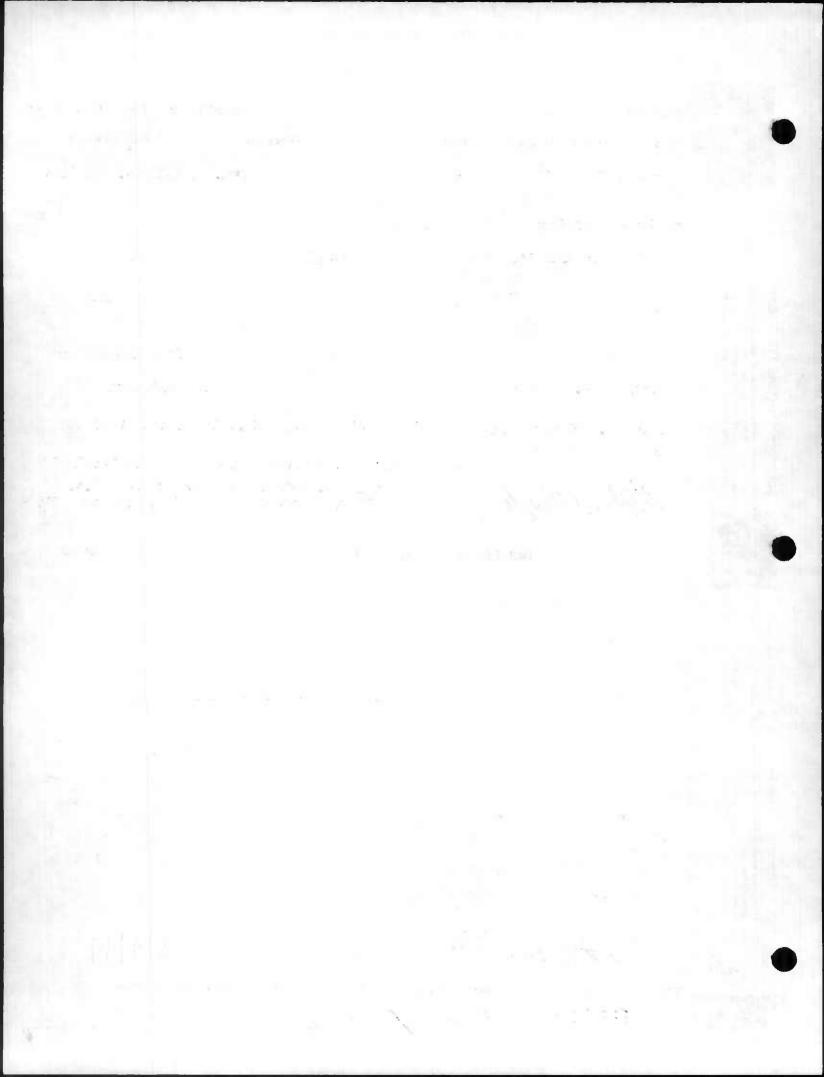
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DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

3. Time of Death

9. Birthplace (State or Foreign

Washington, DC

10d. Inside City Limits

1 Tyes 2X No

11:15 9.12

1999

Physician/Medical þ Completed Be

Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

25. Wes case rafarred to medical

29b. Signetura end title of certifier

DAV. D 5-

1 Yes 2 No

27. Mennar of Death

Natural

2 Accident

3 ☐ Suicide

29a. Cartifier

4 Homicide

Downs

5 Pending investigation

6 Could not be determined

the burial-trensit and 888 signed by it certificate

Records, P.O. Box 68760.

Division of Vital Hospital or Attanding Physician:
 24 hours after deeth.
 Funeral Director: After this certified Certification: To

To the Hosp within 24 hor To the Fune completely fi

State Registrar

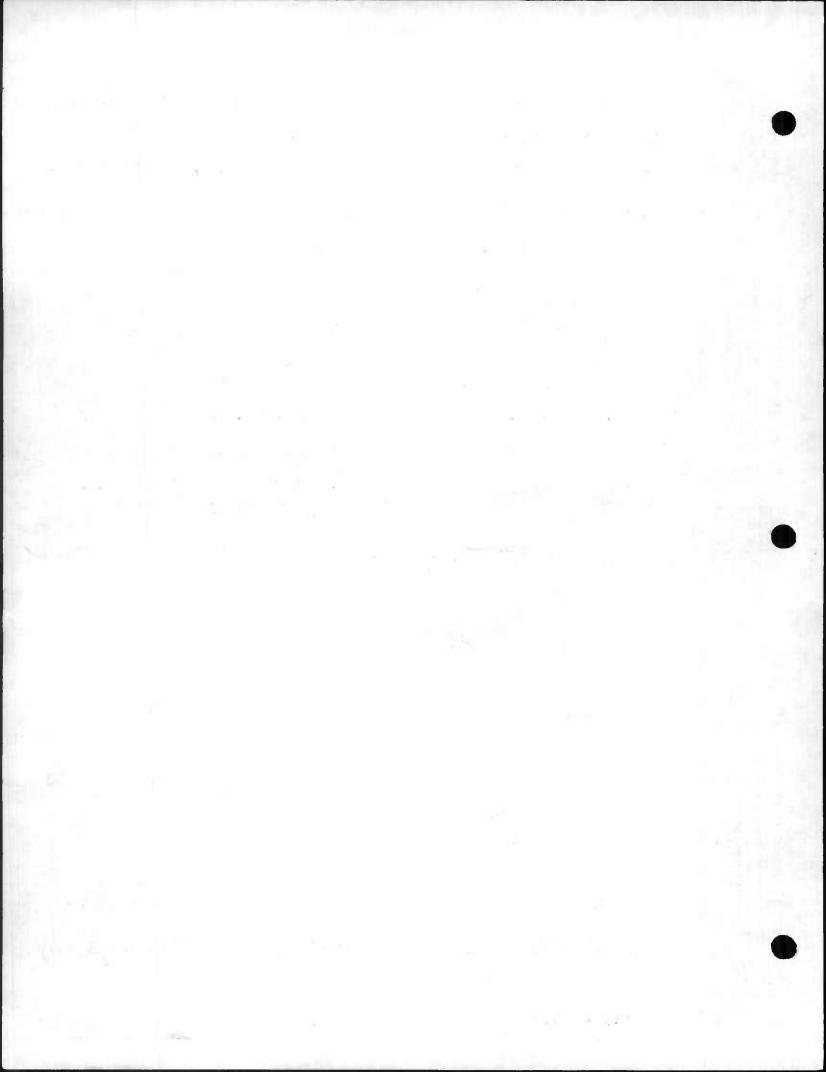
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31. Date filed (Month, Dey, Year)

32. Registrer's Signature

<Tweel Due to (or es a consequence of): Due to (or es e consequence of): Dua to (or as a consequence of) Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy 2 NO 2 No 1 Yes 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 1 ☐ Yes 2 ☐ No 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Pleca of fnjury - At home, ferm, sfreet, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 | Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end menner steted. 29d. Date signed (Month, Day, Year) 29c. License number D3551 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) 615 Wegs **ORIGINAL**



Piease Type or Print in Biack Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Day Month Year 31, 1999 0405 Donald Vincent DiDomenico January 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace Harford 8. Dete of Birth (Month, Dey, Year) If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours Days Months XIXM 2 F 197-05-1914 80 20, 1918 Pennsylvania Apr. Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d Inside City Limits 1 No Yes 2 No Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 206 Baltimore Street 21001 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No WW II If Yes, Give Year or Detes: Korea Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritel Stetus Black, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify Specify: White XXWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Military U.S. Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Adamo DiDomenico Lucia Diantonio 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Andrew F. Chendorani (Son) 747 S. Ruby Lane, Anaheim, California 92807 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Harford Memorial Gardens 2/4/99 4 Donetion 5 Mother (Specify) Entombment Aberdeen, Maryland 21. Signeture of Funeral Survice Licensee 22. Name end Address of Fecility Tarring-Cargo Funeral Home, P. Aberdeen, Maryland 21001-3399 nnely 23a, Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1∏Yes 2∏No 25. Wes case referred to medical exeminer? 26. Placa of Deeth (Check only one) Hospitel: Inpatient 1 ☐ Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death Naturel 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. tnjury et Work? 5 Pending 1 TYes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28e. Plece of Injury - At home, tarm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide

Box 68760 Records, Division 6

Done ld

domenia.

Physician

/Medical

Examiner

Funeral

Director

28a-1 show

6

Items 23a

"natural", or

permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: if Nem 27 is marked other than "nature page."

Physician /Medical

Examine

Examine

Physician/Medical

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Completed

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Certification: To

29a. Certifier (Check only one)

29b. Signeture end title of certified

30. Neme and address of pe

death

72 hours after

Baltimore, Maryland 21215-0020

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Director

Funeral

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Completed

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Medical To the I å

24 hours

Registrar

DHMH 16 Rev 6/95

32. Registrer's Sign

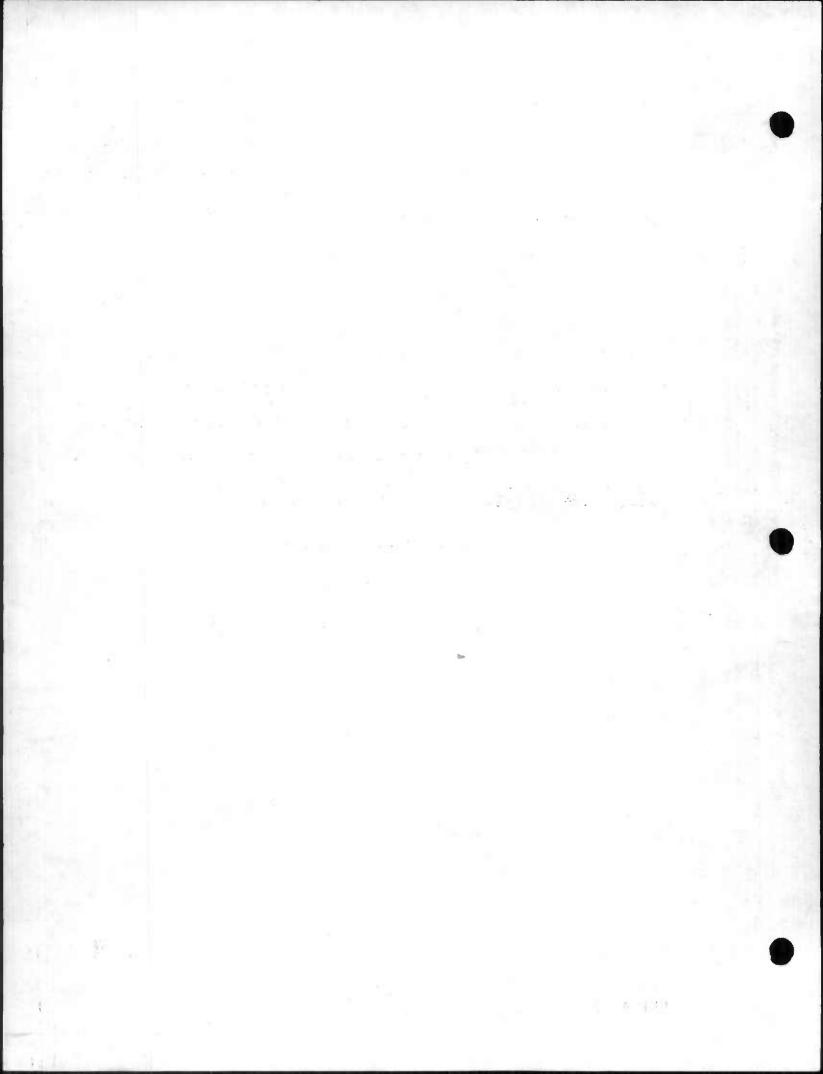
Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated.

29c. License number

29d. Date signed (Month, Day, Year)

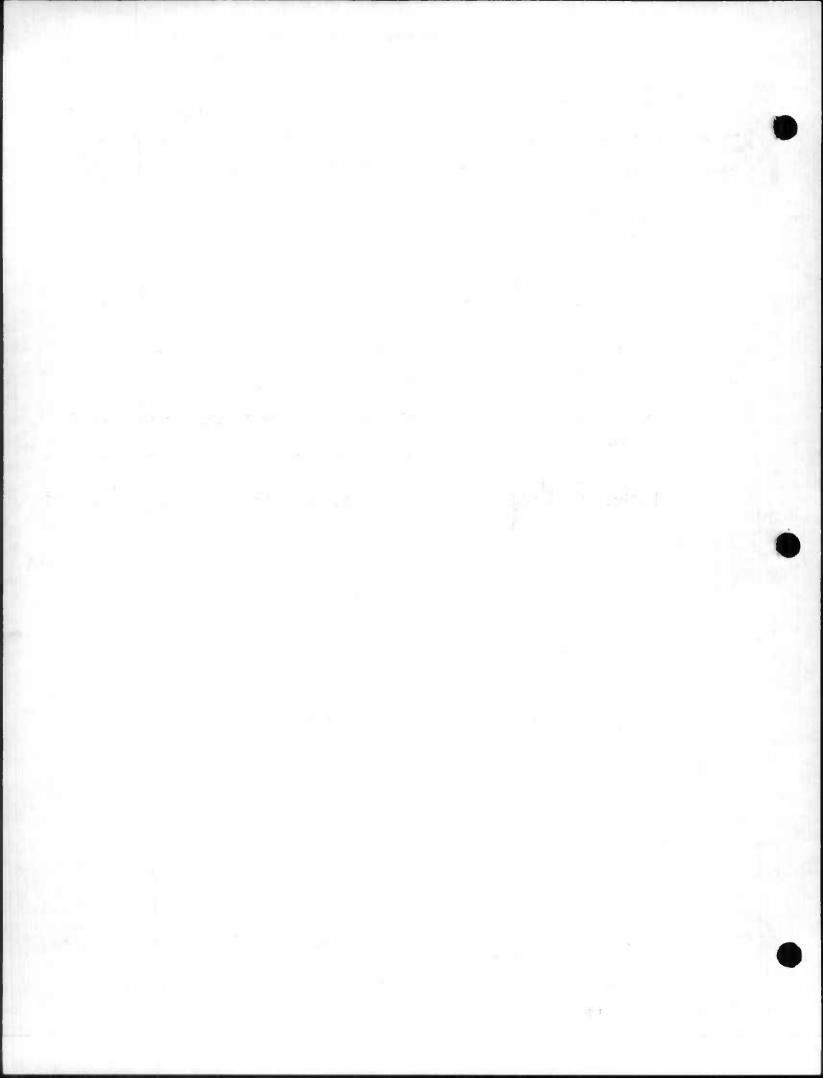
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State of Maryland / Department of Health and Mental Hygiene

				Cer	tificate of	Death	,	Reg. No. 9 9	05 5	
Physic	ian	Dacadant's Nama (First, Middle, Last)					2. Data of De Month		3. Time of Death	
/Medi			onrad		DANI	EL	Februa		999 7:15 PM	
Exami	ner	4a. Facility Nama (If not institution, giva street end nu				4b. City, Town, or L				
		Citizens Nursing Hom 5. Social Security Number 6. Sax			If Undar 1 Yaar	Frederic			derick	
Funeral Director		5. Social Security Number 154-07-1598 Usual Residence of Decedant	7. Aga (In yrs. last	Yrs.	Months Deys		6. Data of Bird (Month, Da Aug. 3	y, Yaar) , 1917	9. Birthplaca (Stata or Foraign Country) Virginia	
Maryland H show	tor	10a. Stata 10b. County Maryland Frederick	10c. City, T Frede		cation				10d. Inside City Limits 1 ☐ Yas Z☐ No	
th with the 23a or 28a	ai Director	10e. Street and Number 5997-D Ladd Court			10f. Zip Coda 21	703		10g. Citizan of V		
s 1 and 2 should be filled within 72 hours after death with the Maryland if Haalth and Mental Hygiena. Item 27 is marked other than "natural", or thems 23a or 28a-f show other traumatic event, the Medical Examiner must be not find as	by Funeral	Armed Fo	edent Ever in U,S. orcas? 2 No va atas 1941-194		Ves Decedent of Yes, specify Cub	Hispenic Origin? (Spen, Maxican, Puarto Specify:	pecify Yes or No Rican, atc.)	14. Rac Blac Specify	e - American Indien, ck, Whita, etc. White	
d within 72 hours af giena. er than "natural", or in the Med cal Exam	Completed	15. Decedent's Education (Specify only highast grada complated) Elementery/Secondary (0-12) College (1		(Giva I life. E	ant's Usual Occu kind of work dona DO NOT usa retire	during most of working d)			nd ot Business/Industry	
Hygie ther ther		17. Fathar's Name (First, Middle, Last)		D.	LICK Mas	18. Mother's Nem	a /First Middle		ruction	
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1 and 2 should be file Haalth and Mental Hy em 27 Is marked oth ither traumatic event		19a Informant's Name/Ralationship (Typa, Print) Mrs. Lillian M. Daniel,	Wife 5	19b. Mailin 599 7–]	g Addrass (Street D Ladd C	ourt, Fre	derick,	er, City or Town, Maryla	State, Zip Code) and 21703	
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permit. Pag Department Important: It any injury o		21. Signatura of Funarel Sarvica Licansea Richau & July	MOO25	55 K	Name end Addre eeney an 06 East	ass of Facility d Basford Church St	P.A. F	uneral :	Home Maryland 21701	
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To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After complately filled in by tha funer	edicai (29a. Certifiar (Check only one) 12 Certifying Physician: To the 2 Medical Examiner: On the band mann	isis of axamination	dge, deeth and/or inve	occurred at the tilestigation, in my o	me, data and plece, opinion, deeth occurr	end dua to tha d red at tha time, d	ceuse(s) end me dete end place,	nnar as stated. and due to tha ceusa(s)	
To the Vithin 2 To the Complain	M	29b. Signatura end title of certifiar			29c. Licens				(Month, Day, Yaar)	
		30. Nama and eddrass of person who completed caus	a of death (Item 23	(Type, P	Print)					
		Austin Pearre, Jr., 1			Winth St	reet, Fre	derick,	Marylan	nd 21701	
Sta	te	31. Data filed (Month, Day Year) 32. R	agistra Signatura		4	/				



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Month Yeer LEE GRANT EDWARD EVANS Feb. 1999 8:10 AM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 2244 Thomas Run Road Bel Air Harford 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dey, Year) 2/19/1922 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) **Funeral** Days Hours Min Yrs Director 177-12-4082 76 Pennsylvania Usuel Residence of Decedent the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23s or 28a-f shov traumatic event, the Medical Examiner main to notified at 1 ☐ Yes 2 No Director Md. Harford Bel Air 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 2244 Thomas Run Road 21015 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 Yes 2 No If Tes, Give Yeer or Detes: WW II permit. Pages 1 and 2 should be filed within 72 hours efter Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or hany injury or other traumatic event, the Medical Exercise 2016. Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry City of Elementery/Secondery (0-12) College (1-4or 5+) Baltimore Night Watchman 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) H. William Evans Mae L. Hilderbrandt 19e. Informent's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Thelma V. Evans/ Wife same as #10 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 2/6 Burial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Bel Air Mem. Gardens 1999 Bel Air, Maryland 22 Name and Address of Fecility E.G. Kurtz & Son Funeral Home, P.A. 21. Signature of Funerel Service Licenspe Jarrettsville, Maryland Madlen 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each one. Approximete Intervel Between Onset end Deeth **Physician** /Medicai Immediate Ceuse (Finel Lung Cancer months disease or condition resulting in death) Examiner Due to (or as e consequence ol): Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest pue Due to (or es e consequence of): ettending physician e for use es the buriel-Box 68760, certificate be Physician/Medicai Due to (or es e consequence of) USB 85 P.O. I signed by the e Pert II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2□ No 3 ☐ Probably 4 ☐ Unknown Records, þ 24b. Were eutopsy lindings evaileble prior to completion of cause of deeth? Be Completed 24a. Wes en eutopsy performed? peen page 2 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attanding Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home **\$CX**Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA To 1 ☐ Yes 2 X No 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 1 Netural 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be Location (Street end Number or Rurel Route Number, City or Town, Stete) Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Y Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted.

2 Medicat Examiner: On the besis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated. 29a. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dev. Yeer) D18779 February 01, 1999 They lex 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Albert S.C. Sun, M.D. 1800 Harford Rd. Fallston, MD 21047 31. Dete filed (Month, Day, Yeer) 32. Registrer's Signeture State Same & Spark FEB 4 Registrar 1999

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** ALMA S. EGGERT 1, 1999 5:30 AM Feb. /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner Hart Heritage Home Harford Street Birthplece (Stete or Foreign Country) If Under 1 Yeer | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dev. Year) **Funeral** 1 M 200 182-01-5179 84 Director Pennsylvania 11/14/14 Usuel Residence of Decedent the Marylenc 10a. State PA 10d. Inside City Limits 10b. County 10c. City. Town or Location YORK Item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at DELTA Street 1 Yes 2 No -Md-Harford-Director 10e. Street and Number 718 Cold Cabin 10f. Zip Code 17314 10g. Citizen of Whet Country? 3708 Grier Nursery Rd. 21154 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours efter deet Depement of Health end Mental thygiene. Important: if Item 27 is marked other than any injury or other traumers. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11. Maritel Stetus Bleck, White, etc. 1 Yes 2 XX If Yes, Give Yeer or Detes: 1 Never Merried 2 Married 1 Yes 2 No Specify:White Specify: þ XXWidowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) 12 Secretary 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Thomas JAckson Clara Sounds 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Clara L. Eckelmeyer -daugh. 718 Cold Cabin Rd., Delta, PA 17314 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 1XXurial 2 Cremetion 3 Removel from State Somerton, PA 19116 Sunset Mem. Park 2/5/99 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility 21. Signature of Funerel Service_Licensee 17314 Harkins F.H. Inc., 600 Main St., Delta, PA 23a. Pax1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete fnterval Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Finel diseese or condition resulting in deeth) ASW **Examiner** Examiner physician end s the buriel-trans Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in deeth) Last Due to (or es e consequence of) P.O. Box 68760. requires that the death certificete be Physician/Medical Due to (or es e consequence of) 80 use signed by the e Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? CABSG, HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed ABETES MELLITUS hes 1 Yes 200 1 Yes 2 No or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) examiner?
11 Yes 2 No
27. Menner of Deeth Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28c. fnjury et NA 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Dey Year) 28b. Time of 1 Natural 2 Accident 5 Pending ne Hospital or Attending n 24 hours efter deeth. Ne Funeral Director: Afte 1 ☐ Yes 2 ☐ No investigation MA NA NA 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of fnjury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide 1 Certifying Phyalofan: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated. 29e. Certifier Medical 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred of the time, date end pleca, and due to the cause(s) and menner stated. (Check only one) within 2 To the

Registrar

ABHU M.0 31. Date filed (Month, Day, Yeer) FEB 3

29b. Signature and title of certifier

32. Registrer's Signature

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

FILFOND ANT BEZAIL MO 21014

DME

29c. License number

29d. Dete signed (Month, Dey, Year)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Anna Eckart 23 1999 January 12:15am 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Mariner Health Care Glen Burnie Anne Arundel | H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Yeer) | May 12, 19 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 1 M 2 KF Months 97 Yrs. 115-01-8676 1901 Germany Usuel Residence of Decedent 10e Stete 10h Counts 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Anne Arundel Glen Burnie 10e. Street end Number 10f. Zip Code 10g. Citizen of Whel Country? 313 Hospital Drive 21061 United States 12. Wes Deceden! Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) unknown Housekeeper Hotels 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) unknown unknown 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Anton Aardrup / Son 411 David Court Palm Harbor Florida 34684 20e. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from State 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 4 ☐ Donetion 5 ☐ Other (Specify) Conestoga Memorial Park 1-27-99 Lancaster, PA 22. Name and Address of Fecility Harry H. Witzke's Family Funeral Home, Inc. 21. Signature of Funerel Service Licensee 0 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Atheroscilevotic Carliovasular Diseas Immediate Cause (Final disease or condition resulting in deeth) Due to (or es e consequence of) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveileble prior to 24e. Wes an eutopsy completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospital: Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of injury (Month, Dey Year)

Physician /Medical **Examiner**

Department of Important: If any Injury or

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-1 show

Peges 1 end 2 should be filed within 72 hours efter death with tent of Health and Menlet Hygiene.
Int: If them 27 is marked other than "natural", or frems 23a or 3au or 3

altimore, Maryland 21215-0020

Director

Funeral

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Physician/Medical þ Completed Be To

Certification: à

the death certificate be executed physician e ettending pt for use es t ed by the e thet signed b should certificate hes b Physician: this After Attending deeth. • Funeral Dire letely filled in b or lefter Hospitai

P.O. Box 68760

Records,

Division of Vital

Medical To the within 2 To the

29b. Signature and title of certifier 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

5 Pending investigation

6 ☐ Could not be

27. Manner of Deeth

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

31. Dete filed (Month, Day, Year) JAN 26 1999

BUB MO

32. Regist ar's Signeture

28b. Time of

28e. Plece of Injury - At home, farm, street, factory, office full order, etc. (Specify)

28c. Injury et Work?

🗠 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end menner stated.

29c. License number

1 Yes 2 No

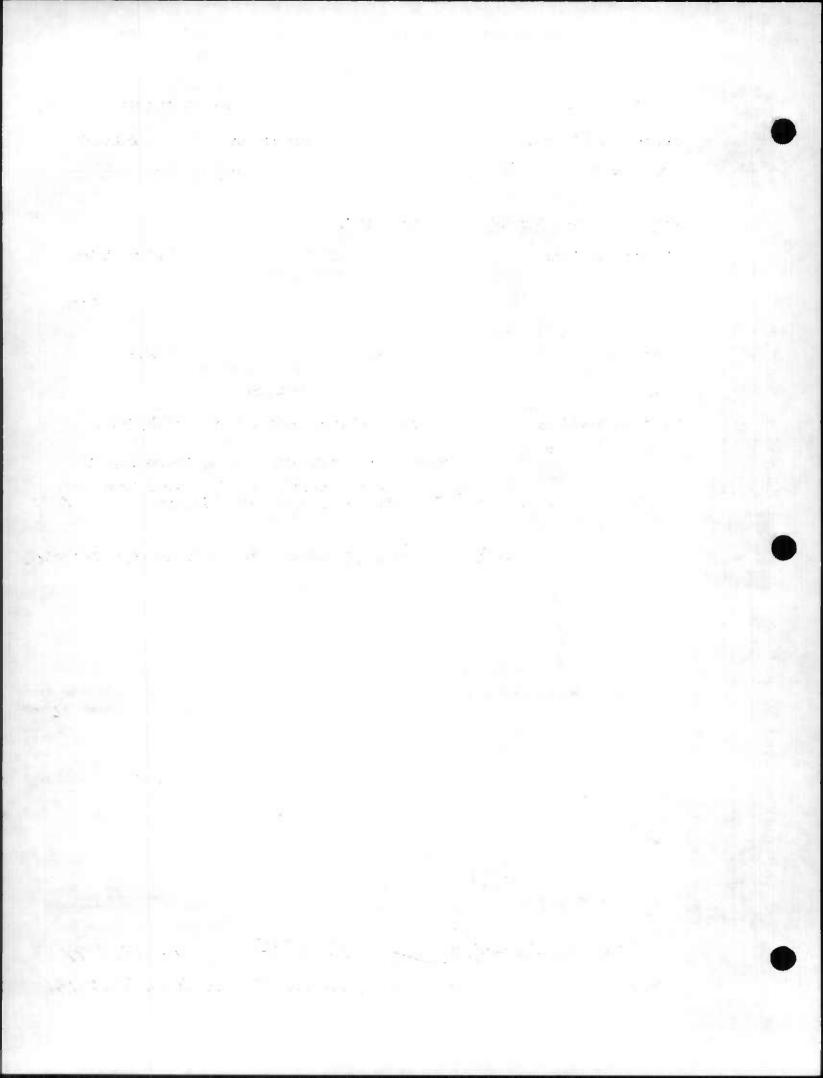
29d. Dete signed (Month, Dey, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

28d. Describe how injury occurred

25 Main St. Review town Md2/136

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Death 3. Time of Death Month 4a. Fecility Name (If not institution, give street and number) ucille Am Feb 08 15:25 1999 4b. City, Town, or Location of Deeth 4c. County of Death Hunder 1 Year | Hunder 24 Hrs. | 8. D 5. Social Security Number OF MARYLAND Baltimore 8. Date of Birth 9. Birthplace (State or Foreign Country)
March 4, 1943 Washington, D.C. 6. Sex 7. Age (In yrs. last birthday) Months Hours 1□M 20 F 220-40-5880 55 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Frederick 1 Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 212 East Church Street 21701 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2M No If Yes, Give Year or Dates: 11. Maritel Status 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 5College (1-4or 5+) Elementary/Secondary (0-12) Reading Specialist Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) William Bea11 Bowie Lucille Kurvers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Judge John H. Frye III, Husband 212 East Church Street, Frederick, MD 21701 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Smithsburg Crematory, February 10, 1999 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Keeney and Basford P.A. Funeral Home 21. Signature of Funeral Service License MO0255 106 East Church St., Frederick, MD 23a. Pert1. Enter the disease, or compilcations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ~ 48 hours Intestraci

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a State

Director

Funerai

Completed by

Be

Funeral

Director

parmit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiena. Important: if itam 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, in Medical Example Investor not the notified an once.

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 64 hours after death.

To the Funeral Director: After this cartificate has been signed by the attending physician and completely filled in by the tunerel director, page 2 should be detached for use as the burlet-transit

Division of Vital Records, P.O. Box 68760,

resulting In deeth)	Due to (e	-> / I I I (C.)		1	1. G MEN.
Sequentially list conditions, if erry, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Intra-al Due to (c	~ 48 hours			
resulting in death) Last	Due to (or es a consequence of):	~5 days			
Pert II. Other significant conditions					
				performed?	
25. Was case referred to medical			26. Piece of De	eath (Check only one)	
examiner? 1 No	Hospital:	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Residence 6 □Oth	ner (Specify)
2 ☐ Accident investigati	28a. Date of injury (Month, Dey Yeer)	injury	28c. injury at Work?		
	d 28e. Place of Injury - At he	ome, farm, street, fact y)	ory, office		per or Rural Route Number,
(Check only 2 Medical Ex	iminer: On the basis of examina	wledge, death occurre tion and/or investigation	ed at the time, date and place on, in my opinion, death occ	e, and due to the cause(s) end me urred at the time, date and place,	enner es stated. end due to the cause(s)
29b. Signature and title of certifier		2	9c. License number	29d. Date signe	d (Month, Dey, Year)
1 Vauven	Bunditt	UD CIN	P10274	1816	99

22 S. Greene Street, Baltimore, MD 31301

Maurien Burditt W

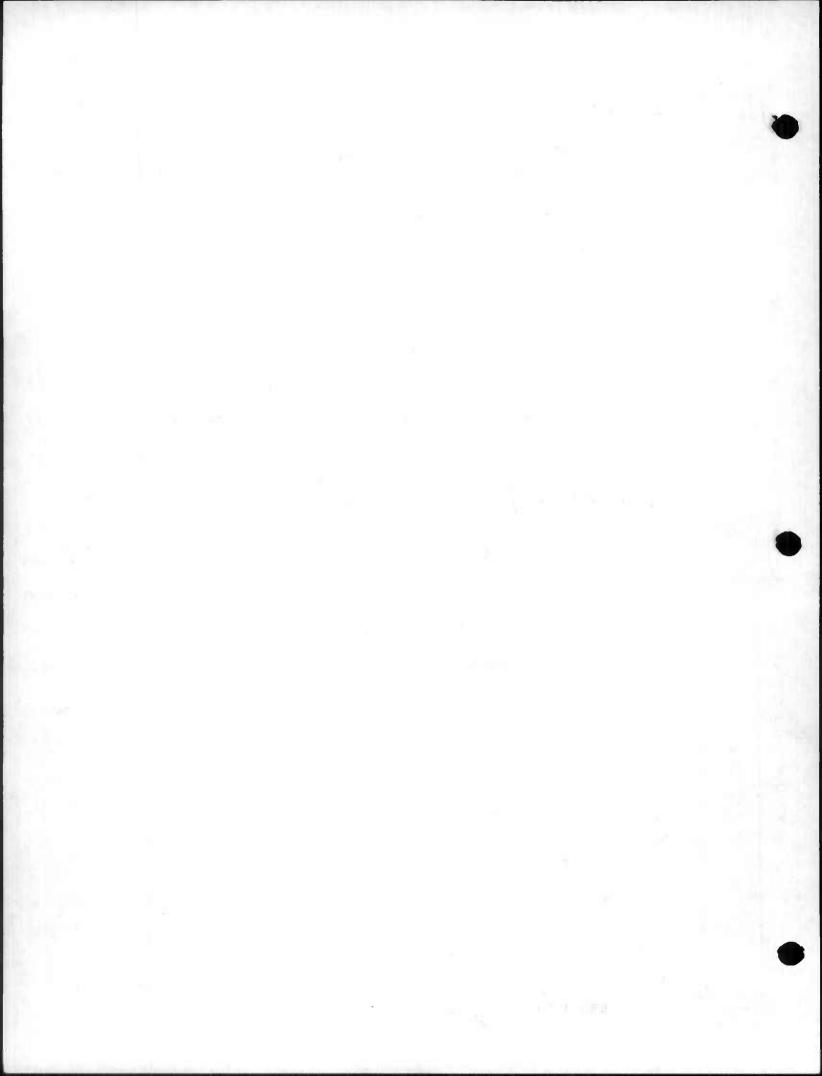
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

NO 1999 Signature

Maureen Burdett

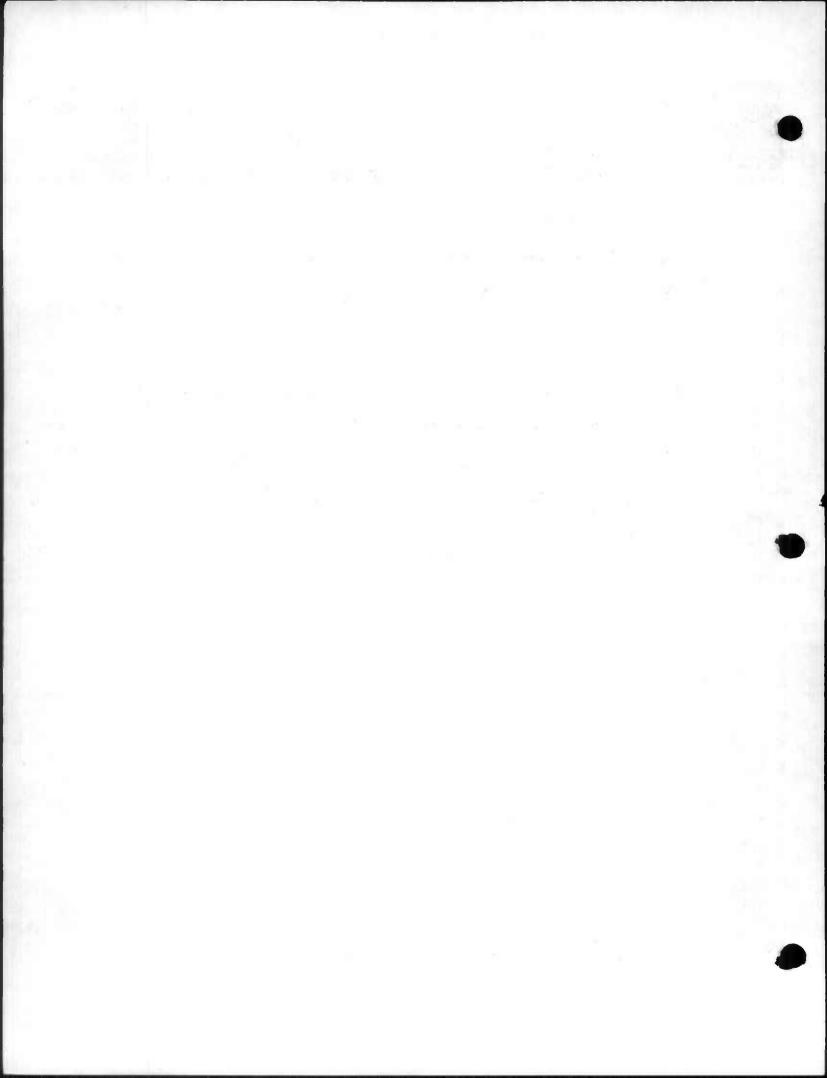
31. Date filed (Month,

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician		1. Decedent's Neme (First, Middle, I	l ast)		Certif		Doain	2. Dete of Dee	leg. No. 🤍 💢	UOI	of Deeth
	1	John Cochi	n Frenc	6				Month	Dey	Year	MA
/Medical Examiner		a. Fecility Neme (If not Institution, s					4b. City. Town, or	Location of Deeth	4c. County of	/	
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uneral			Sex 7. A		lest birthday) If	Under 1 Yeer onths Deys		8. Date of Birth	Vand	9. Birthptace (Star Country)	e or Foreign
irector	215-53-0248 11 M 2□ F Yrs. S 20 Hours Min. (Month, Dey, Year) Usuet Residence of Decedent										AND
MO III		10e. Stete 10b. County		10c. Ci	ity, Town or Location	on		·	City Limits		
r 28a-1 show profited at	2	MD Hou	ARD	E	LLICOTT	C17	Y			1 🗆 Y	es 2/No
or 28		10e. Street end Number			1	Of. Zip Code		1	0g. Citizen of W	het Country?	
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nt, the Medical		(Specify only highest g	coilege (1-40)	5+)	(Give kind	of work done	during most of wa	rking	Tob. Kind of bus	—	
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traumatic		19e. Informent's Name/Relationship	(Type, Print)		19b. Meiling A	ddress (Stree		urel Route Number	. City or Town. S	State, Zip Code)	
er tre	L.	JOHN BRAMO FR	ENCH F	ATHER	9231	SPAI	NG LAL	LEY RO		mo. 210	
or other	2	20a. Method of Disposition 1 M Buriat 2 ☐ Cremetion 3	CD	20b. F	Plece of Dispositio cemetery, cremato	n (Neme of ry or other ple	ce)	Dete	20c. Location - C	City or Town, Stete	
		4 Donetion 5 Other (Spec		M	cemetery, cremato	Eu C	EMETERY	2/9/99	MARYL		, ,
any injury or	4	21. Signature of Funeral Service Lic	ensee					5 Y L.F.O.			
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clan er. ouriel-tr		Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or Injury	6	Due to (d	or es e consequen	ce of):					
es the		Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest	c		or es e consequend						
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• Funeral Director: After this certificate has been signed by the ettendir plately filled in by the funeral director, page 2 should be deteched for use edical Certification: To Be Completed by Physician/A	F = 2	Pert It. Other significent conditions 25. Wes case referred to medicat examiner? 1	Hospitat: 1 Hepat 28e. Dete of Inj. (Month, D 28e. Ptace of Ir building, e	but not res	DER/Outpatient 3 28b. Time of Injury 1 ome, ferm, street, by	iying cause gi DOA 28c. Inju Wo 1 factory, office	26. Ptace of Dener: 4□ Nursing Fry at rk? Yes 2□ No	ath (Check only on tome 5 Reside 28d. Describe house 1 City or Town 1, and due to the curred et the time, d	n eutopsymed? ss 2 No ne) nece 6 Other ow Injury occurre reet end Number n, Stete) euse(s) end man ete end ptace, er	24b. Were eutope eveitable pricompletion of deeth? 1 Yes 2 (Specify) d r or Rurel Route N ner es steted. d due to the ceus	Unknown y findings or to of cause No No
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Tima of Death 2. Dete of Deeth 1. Decedant's Nama (First, Middla, Last) **Physician** February 04, 1999 Charles Edward Fulton 11:35 am /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Nama (If not institution, give street and number) Examiner 408 Laurel Avenue Prince George Laurel If Undar 1 Yaar | If Under 24 Hrs. 5. Social Sacurity Number 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foreign 8. Data of Birth (Month, Day, Year) **Funeral** Days Hours 18 M 2□ F 218-20-0083 88 Yrs. Maryland Director Aug 23, 1910 Usuel Rasidance of Dacedani the Maryland r 28a-f show 10a. Stata 10b. County 10c. City, Town or Location 10d. insida City Limits 1 X Yas 2 No Directo MD Prince George Laurel 10g. Citizan of What Country? 10e. Street end Number 10f. Zip Coda with ?? Is marked other than "natural", or items 23a or traumstic event, the Medical Examinar must be a 408 Laurel Avenue 20707 USA death v Funeral 12. Was Decedant Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Raca - Amarican Indian, Black, Whita, atc. 1 ☐ Yes 2 No If Yas, Giva Yeer or Detes: 1 Navar Married 2 Married Specify: White Maryland 21215-0020 1 Yas 2 No Specify: P 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Spacify only highast grede completed) 16e. Decedent's Usuai Occupation 16b. Kind of Businass/Industry (Giva kind of work done during most of working lifa. DO NOT usa retired) Elementary/Secondary (0-12) College (1-4or 5+) Grade 11 Night watchman Auto Dealership 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) 2 should be fi and Mental H is marked ot William Andrew Fulton Lilymae Schaffer 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Itam 27 is n any injury or other traun once. /nephew Richard F. Bedell 408 Laurel Avenue, Laurel, Maryland 20707 20b. Place of Disposition (Nema of camatary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Crametion 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 2/8/99 Ivy Hill Cemetery Laurel, Maryland 22. Name and Address of Fecility
Donaldson Funeral Home, P.A. 21. Signatura of Funaral Sarvice Licarcas 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Part1. Enter the distrible, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart further. List only one cause on each line. Approximate Intervel Between Onset and Daath **Physician** Immediata Cause (Final diseese or condition resulting in death) Progressive Renal Failure 2 years Examiner Dua to (or as a consaquance of) Examiner Dehydration the attanding physician and hed for use as the bungl-transit death certificate be axecuted Sequantially list conditions, if any, laading to immediate cause. Enter Underlying Ceuse (Disease or InJury that initiated avants resulting in death) Last Dua to (or as a consequenca of): P.O. Box 68760, Physician/Medical Dua to (or as a consaquance of): USB BS ed by the a detached f 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown signed t Malnutrition Records, by 24b. Wera autopsy findings available prior to 24a. Wes an autopsy Completed Congestive Heart Failure complation of causa of death? certificate has 1 Yes 2 No 1 ☐ Yas 2 ☐ No Anemia of Vital 25. Was case rafarrad to medical axaminar? Be 26. Placa of Daath (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 ☐ Nursing Homa 5 🕅 Rasidance 6 ☐ Othar (Specify) 70 1 Yas 2X No funeral 28e. Dete of Injury (Month, Day Year) 28d. Dascribe how injury occurred 27. Mennar of Death 28b. Tima of 28c. injury at Work? Certification: Division 5 Panding invastigation 1 Natural s after daath. 1 Yas 2 No 2 Accidant tha 6 Could not be 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, atc. (Spacify) filled in by 4 - Homicida ö Hospital 24 hours 15 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the causa(s) and menner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, dete and place, and dua to the causa(s) and manner stated. within 24 hot To the Fune completely fi Medical 29a. Certifie (Check only one) the 29b. Signatura and titla of certifian 29c. Licansa number 29d. Data signed (Month, Day, Year) 0 30. Nema and address of person who completed causa of daeth (Item 23a) (Typa, Print) 10 8317 Cherry Lane, Laurel, Maryland 20707 Laura Weber, M.D. 31. Data filed (Month, Day, Year) 32. Ragistrar's Signature FEB 0 9 1999 Registrar

en mark

DHMH 16 Rev 6/95

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NAMES OF BUILDINGS ASSESSED.

B.K.S

* Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

KENNETH MICHAE	EL FOX	State of Manuand / D

MICHAEL FOX	State of Maryland / Department of Health and Me	ntal Hygiene	05150
ITEMS: #23 PART I,	State of Maryland 1. Department of Health and Me 27, 28A-F PER MEO G768 Certificate of Death	Reg. No.	00100

Physician	
* /Medical	_
Examiner	4
LAGITITICI	

29d. Date signed (Month, Day, Year) 8, 1999

FEB.

111 Penn Street, Baltimore, Maryland 21201

Fun Dire

permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Health and Mental hygiena. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show

Baltlmore, Maryland 21215-0020 **Physic** /Med Exami

To the Hospital or Attending Physician: The law requires that the death certificata be assecuted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completaly filled in by the funeral director, page 2 should be detached for the service has been the hours. Division of Vital Records, P.O. Box 68760,

1. Decedent'a Name (First, Middle,	Last)	IIII/Y-		100		UOT.		2. Dete of De		Vans	3. Time of Dea
Kenneth Mic	chael Fox							Month FEB.	7, 1999	Year	10:05
4a Fecility Name (Il not Institution,	give street and number)				4b.			ocation of Death	4c. County	of Deeth	
303 EDGEWOOD	ROAD APT.#C					ED	GEWC	OOD	HAR	FORD	
5. Social Security Number 6		e (In yrs. last		If Under 1 Ye		If Under Hours	24 Hrs. Min.	8. Date of Birt	h Year)	9. Birthp	lace (State or Fo
217-64-0594	1 3 3 M 2□ F	43	Yrs.	NOTITIES DE	ys	riouis	IVIII).	October	6,1955	Mary	lace (State or Fo ity) Land
Usual Residenca of Decedent											
10a. State 10b. County		10c. City, I	own or Local	ion						1	0d. Inside City Li
Maryland Har	ford		Edgew	bood							1 □ Yes 2€
10e. Street and Number				10f. Zip Cod	ie				10g. Citizen of V	What Cour	itry?
303 Edgewood Ro	oad			2	2104	40			U	SA	
11. Maritel Status	12. Was Decedent E Armed Forces?	Ever In U,S.	13. Wa	s Decedent	of Hiss	panic Ori	gin? (Sp	ecify Yes or No Rican, etc.)		a - Americ	
1 ☐ Never Married 2 ☐ Marrie		lo				Specify:	i, i doite	r tiouri, oto.,			
3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		, ,	Yes 2/2	140	Specify.			Specify	. Wn	ite
15. Decedent's		1	6e. Deceden	it's Usuel Oc	cupeti	ion	t of work	rina	16b. Kind of Bu	usiness/Inc	dustry
(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO	d of work do NOT use re	tired)	ary IIIUS	. Or WOIR	unig.			
12			Cab Dr	iver					Trans	sport	ation
17. Father's Name (First, Middle, La	ast)				1	18. Mothe	r's Nam	e (First, Middle,	Maiden Suman		
David Lee Fox					I	Delia	a An	n Wain			
19e. Informent's Neme/Reletionship	p (Type, Print)		19b. Mailing	Address (Str	eet an	nd Numbe	er or Rui	ral Route Numbe	er, City or Town,	Stete, Zip	Code)
David L. Fox/ Fa	ther	1	1054 C	aracar	a (Cir.	, La	keland,	FL 338	09	
20a. Method of Disposition		20b. Place	a of Dispositi	on (Name of	f			Date	20c. Location -		wn, Stete
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		Due to (or as	a conseque	nce of):							
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cause. Enter Underlying Cause (Disease or Injury that initiated events	C	Due to (or se	e conseque	nce of):						1	
resulting in death) Last			2 0000400							1	
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	and the state of t		g oro unde	.,	3.,011	31(1			Yes 2□ No		
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OF Monantaria								1 🗹		116	Pres 2□ No
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2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	2-7-99		und: 8:25			99 ZIVI	140	UNKNOW			d Bouts M
4 Homicide determin	ed 28e. Placa of Inju- building, etc	iry - At home :. (Specify)	, farm, street	, factory, off	ice			City or Tox	orreet and Numb vn, State) 30	3 EDGE	WOOD RD.,
		FOUND A							, MARYLAN		
29a. Certifier 1 ☐ Certifying (Check only)	Phyaicfan: To the best of camfiner: On the basis of	f my knowled	dge, death or	courred at the	e time	, date en	d plece,	and due to the	cause(s) and ma	anner as s	tated.
one)	and menner ste	ted.	LINE OF HIT 03	"Serioti, iii ii	.y opii		ur occur		auto una piaca,	-114 446 (1	00000(3)
29b. Signeture end title of cartifina	1011			29c. Lic	ense r	number			29d. Date signe	d (Month,	Day, Year)

State Registrar

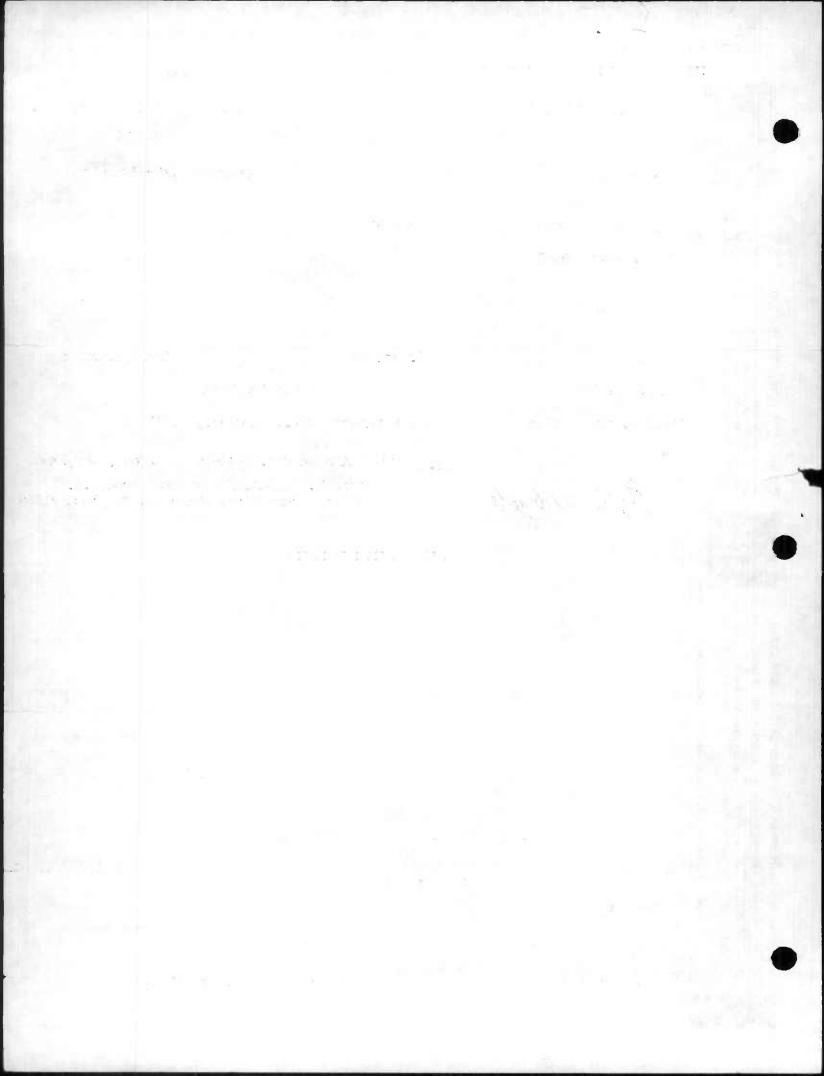
31. Date filed (Month, Dey, Year) FEB 2 4 1999

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis J. Chute, ND 1111 F

O.C.M.E



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 9 9

			State of Ma	aryland		artmen rtificate			nd M		jiene leg. No. 9	9 0	515	9
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	ter death with the Maryland reting 23s or 28s-1 show fret must be notified at	Usuel Rasidence of Decedent 10a. Stete 10b. County Maryland Harford 10e. Street and Number	vland Harford Chur						10d. Inside 1 □ Ye Rode 10g. Citizen of What Country?					ty Limits 2 No
	3a or		ne				2102	28						
020	urs a	11. Merital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Yeer or Detas:				lent of H afy Cuba	nt of Hispanic Origin? (Specify Yes or No- y Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Ir Bleck, White, etc.					etc.	
21215-0020	within 72 and. then "nate	15. Decedent's Et (Specify only highest gra Elementery/Secondary (0-12)		5+)	(Giva	dent's Usue kind of wor DO NOT us naker	k done o	during most	of worki	16b. Kind of Business/Industry Own Home				
Maryland	Hal H	Moffit Isaac Brown Maud							(First, Middle, Elizak	Maiden Sumer eth Br			14	
lan	s marke sumatic	19e. Informent's Name/Relationship (Type, Print)		19b. Maili	ng Addrass	(Street	and Number	r or Rura	I Routa Numbe	, City or Town	, Stata, Zip	Code)	721
	Pegas 1 and 3 tent of Health m: If Nem 27 iry or other tr	Roy Good / Son 20a. Method of Disposition 150 Burial 2 Cremetion 3		Ce	ece of Dispo matary, cre	osition (Nem metory or of	ne of ther plac	e) .	2-	-2-99	20c. Location	- City or To	own, State	
Baltimore,	permit. Pega: Department of Important: If I any injury or page.		Bel Air Memorial Gardens Bel Air Memorial Gardens Bel Air, Maryland 22. Nama and Address of Facility Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009											
	Physician /Medical Examiner	23a. Pert1. Exter the decrease, or companies, or heart failure. List only immediate Cause (Finel disease or condition rasulting in death)		chro	Do not en	ter the mode	e of dyin	g, such es d	ardiec o	r respiretory err		1	Approximete Intervel Bet Onset end I	e ween
Box 68760,	at the death certificate be executed by the attending physician and letached for use as the bunk-transit Physician/Medical Examiner	Cause (Diseese or injury that initieted events resulting in death) Last	c		as a consec as a consec									
	death e atter od for	Pert II. Other significant conditions or	notributing to death by	ut not recul	lting lo the u	nderlying co	ause aka	an in Part I		23h Did to	obacco usa co	ntribute t	o the cause (of death'
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Division of			28a. Dete of Inju. (Month, De)	ry y Year)	28b. Time o Injury	M 21	8c. tnjun Worl		io	ne 5 Residence 1986. Describe h	ow injury occu	red		har
DIV	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completaly filled in by the funeral Medical Certification: "		building, atc	of my know	rledge, deatl	n occurred e	et the tim	ne, date end pinion, deat	place, e	City or Tow	n, Stete) ausa(s) and m	annar as s	stated.	
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	,	20 Name and address of passes who			00-1 (T	D-i-A						1		

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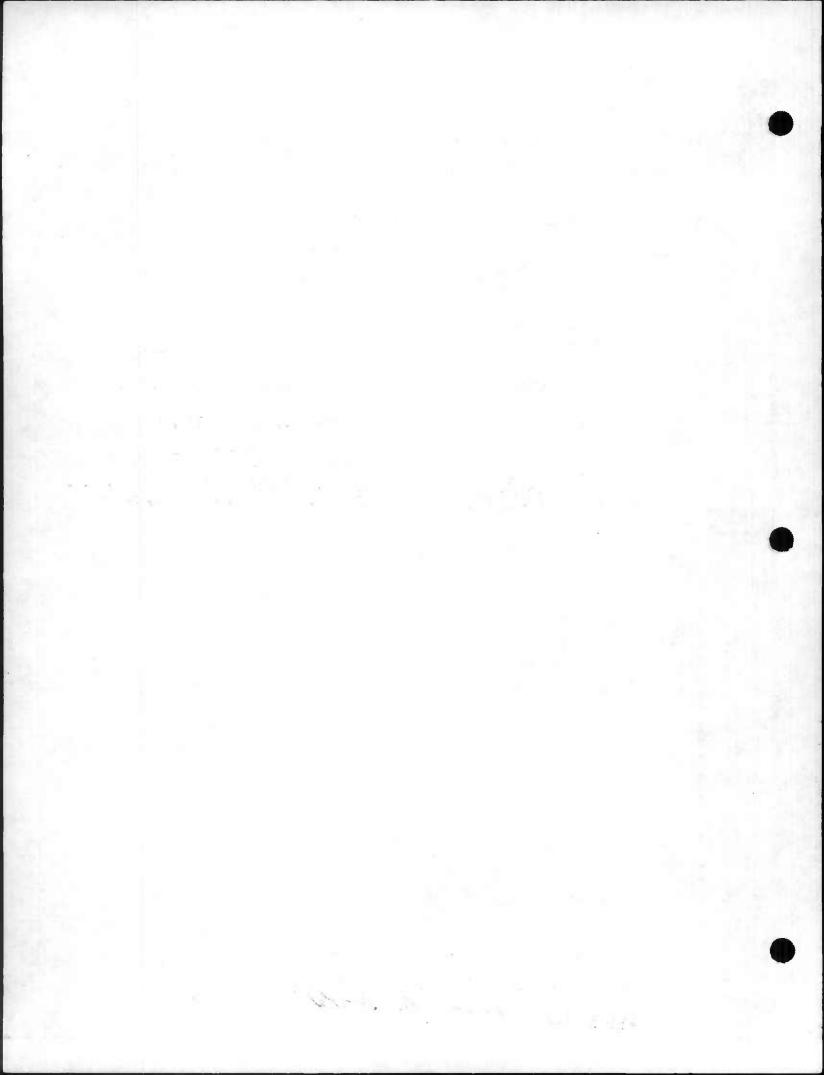
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31. Dete filed (Month, Day, Year)

d cause of death (Item 23a) (Type, Print)

2 North Avenue Bel Air Mary and 21814

32. Degistrer's Signeture



Ammmended Harford County HEalth Dept. Line #1 KDG Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

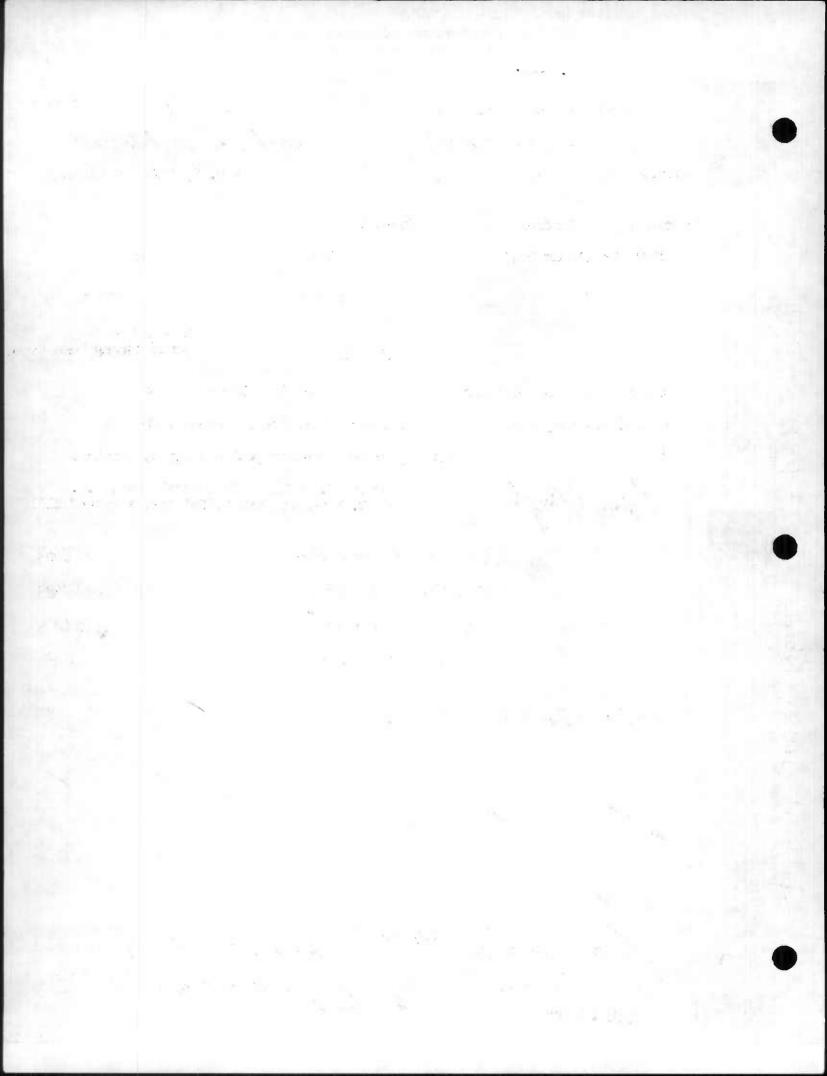
Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) DELMAR ROBERT GULLION Month **Physician** :01 9 1999 4c. County of Death GULLION FeB. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner YEMOR IAL Havre de 8. Date of Birth (Month, Day, Year) MRFORD HARTORD If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1⊠M 2□ F Yrs. 213-26-0448 9, 1929 Director 69 Apr. Virginia Usual Residence of Decedent the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28a-f show traumatic event, the Medical Examiner mantice notified at 1 ☐ Yes 2X No Directo Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1211 Van Bibber Road 21040 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Sand & Gravel filed within 7 Hygiene. 2121 and Mental Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Truck Driver Baltimore, Maryland 18. Mother's Name (First, Middle, Malden Sumeme) 17. Fether's Name (First, Middle, Last) Be should be Tibbs Gullion Lincoln Annie Irene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 end 2 st Department of Health and Important: If Item 27 Is in any injury or other traun 1211 Van Bibber Road, Edgewood, MD 21040 Doris H. Gullion/Wife 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 20a. Method of Disposition 20c. Location - City or Town, Stete 1⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Lutheran Cemetery2-13-99 Joppa, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Neme end Address of Fecility Howard K. McComas III Funeral Home, P.A. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest,

Approximete

Approximete Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner ARETTE attending physician end for use as the burial-transi Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest WIMONALA Due to (or es e consequence of) LUNG Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. ed by the a 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown NON INSUINDER DIA BeTES P The law requiras 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? Completed 24e. Was an autopsy performed? certificeta hes t 1 Yes 1 ☐ Yes 2 ☐ No director, 25. Was cese referred to medical exeminer? Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2€ No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending n 24 hours after death.

ne Funeral Director: Af pletaly filled in by the fu 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide ò Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and His of certifi 29c. License number D40922 mpleted cause ot deeth (Item 23e) (Type, Print) SOUTH UNION AVE. HOURE de GODACE, MD 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Day **Physician** 1999 6:35 Pm 31 Geneva (nmn) Grafton JANUARY /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner Fallston General Hospital Fallston Harford If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplaca (Stata or Foraign Countly) Feb. 14, 1905 North Carolina 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months 1□ M 20XF Days Yrs. 93 Director 213-12-2672 Usual Residence of Deceden 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21014 USA 2228 Conowingo Rd. Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☒No If Yes, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 1 Nevar Married 2 Married Specify: White 1 Yas 2 No Specify: þ 3 ₩idowed 4 Divorcad Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Own Home 8 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Caudell Celia Ann Brown Benjamin (nmn) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) P.O. Box 10, Forest Hill, MD 21050 Charles Phillips/Son In-Law 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gardens 2-5-99 Bel Air, Maryland 4 Donation 5 Other (Spec 21. Signature of Funeral Service Light 22. Name end Address of Facility Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a Part First the disease, or obmolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting In death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Diseese or Injury that initieted events resulting in death) Last Physician/Medicai ce of): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) Be Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year)

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JRAFTON, GENEVA

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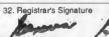
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altimore, Maryland 21215-0020

31. Date filed (Month, Day, Year)

1999

30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print)





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Registrar

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Barrier Branch Branch

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Neme (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **Physician** 81014 January 31 1999 Hurley Theresa Mary /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Nama (If not institution, giva street and number) **Examiner** Bel Air Mariner Health of Bel Air Harford Birthplace (Steta or Foraign Country) 8. Data of Birth (Month, Day, Yaar) 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) **Funeral** Deys Hours Min. 1 M 35F 82 Yrs. Director 082-24-3069 April 4, 1916 Pennsylvania Usual Rasidanca of Dacedant the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show 7 is marked other than "naturel", or frems 23a or 28a-f shot traumatic event, the Medical Examiner must be notified at 1 Yas 2 No Directo Maryland Harford Kingsville 10g. Citizan of What Country? 10e. Street end Number 10f. Zip Coda permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Mental Page or 2000. 2704 Jerusalem Rd. Funeral 21087 USA 12. Was Decedent Ever in U.S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yas, Giva Yaar or Datas: Raca - American Indian, Black, Whita, atc. Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yas 2 ☒ No Specify: þ Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Clerk Banking 12 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nema (First, Middle, Meidan Sumama) Be 2 Mary (uk) Andrew (u/k)Kruly 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) Patricia Sweeney/ Daughter 2704 Jerusalem Rd., Kingsville, MD 21087 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other Specify 2-3-99 Bronx, New York Raymonds Cemetery 22. Nama and Addrass of Facility
Howard K. McComas III Funeral Home, P.A. ture of Funaral San 1317 Cokesbury Road, Abingdon, MD 21009 Pal 1. Entar the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or raspiretory errest, theck, or heart failure. List only one cause on each line. Approximata Intarval Between Onsat end Daath Physician Immediata Causa (Final disaasa or condition rasulting in daath) /M dical 3 years Examiner Dua to (or as e consequence of) Physician/Medical Examiner sician and burial-transit The law requires that the daath cartificate be executed Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disaasa or injury that initiated avants rasulting in death) Last Dua to (or as a consequence of) physician s the burial Dua to (or as a consequence of) signed by the atte Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performad? Completed To the Hospital or Attending Physician. The servicing 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2: 1 Yas 2 No 1 Yas 2 No Be 25. Was casa refarred to medical examinar? 26. Pleca of Daeth (Check only one) 2/Nary Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 1 Yas 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury et Work? 1 Naturel 5 Panding 1 Yas 2 No Invastigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, daath occurred at tha tima, data and place, and dua to tha cause(s) and manner as steted.

2 Medical Examiner: On tha basis of axamination end/or investigation, in my opinion, daath occurred at tha time, dete end place, end due to tha ceusa(s) and manner steted. edicai 29a. Cartifiar (Check only one) 29d. Data signad (Month, Dev. Year) 29b. Signature end titla of cartifiar 29c. License number 30. Nama and address of person who complated causa of daath (Itam 23a) (Type, Print) Bel Air Maryland 31. Data filed (Month, Day, Year) 32. Ragistrer's Signatur State Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 1. Decedent's Nama (First, Middla, Last) **Physician** 3/ 1999 2:45pm 600er1 4b. City, Town, or Location of Death /Medical 4c. County of Deeth 4a Facility Nama (If not institution, giva street and number) **Examiner** Howard County General Hospital Columbia Howard If Under 24 Hrs. B. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) if Undar 1 Year 6. Sex 1 M 2 □ F Birthplace (Stata or Foreign Country) 5. Social Sacurity Number **Funeral** Days Yrs. 579-26-1872 73 Director March 31,1925 Connecticut Usual Residence of Decedant the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits r 28a-f show 1 ☐ Yas 2 No Directo Maryland Howard Columbia 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? with r than "naturel", or items 23s or the Wedical Examiner must be r 10109 Windstream Drive 21044 United States Pages 1 and 2 should be filed within 72 hours after deeth vient of fatalith and Mantel Hygiene.

mit: If item 27 is marked other than "naturel" or farms 23, ury or other traumatic event, the Maulcal Evantion mail ury or other traumatic event, the Maulcal Evantion mail. Funeral 12. Was Decedant Ever in U,S. Armad Forcas? 1∑ Yas 2 □ No if Yas, Giva Year or Detas:1942-46 14. Raca - American Indien, Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 11. Maritel Status Black, Whita, etc. 1 Navar Married 20 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grada complated) College (1-4or 5+) Elemantary/Secondary (0-12) Owner Real Estate 18. Mothar's Nama (First, Middla, Maiden Sumama) 17. Fether's Name (First, Middla, Last) Be Robert Price Henderson Helen Wade 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Kathleen Henderson/Wife 10109 Windstream Drive Columbia, MD 21044 20b. Plece of Disposition (Nama of cematary, crematory or othar placa) 20c. Location - City or Town, Stala 20a. Mathod of Disposition 1 ☐ Burial 2X Cramation 3 ☐ Ramoval from Stata permit. Page Department of Important: If I eny injury or 4 ☐ Donation 5 ☐ Othar (Specify) Catonsville, MD Metro Crematory 2-2-99 22. Nama and Addrass of Facility Harry H. Witzke's Family Funeral Home, Inc. 21. Signature of Funaral Servica Licansaa 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disaasa, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in death) Examiner Dua to (or as a consequance of): Examiner physicien end the buriel-trensit the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avents rasulting in death) Last Dua to (or es e consaguança of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequance of): 98 use jo signed by the a 23b. Did tobecco use contribute to the cause of deeth? Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings availabla prior to complation of causa of daath? should Completed 24a. Was an autopsy pege 2 s has 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate director 25. Wes casa rafarrad to medical axaminar? Be 26. Placa of Daath (Check only ona) Othar: 4 Nursing Home 5 Rasidance 6 Other (Specify) 20 No P 1 Yes 1 Inpatiant 2 ☑ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28d. Dascribe how injury occurred 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? Certification: After or Attending 1 Natural 5 Panding invastigation 1 Yas 2 No 24 hours after deeth.

Funeral Director: A 2 Accident the 6 Could not be datarminad Location (Street and Number or Rural Routa Number, City or Town, State) 3 ☐ Suicide 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) filled in by 4 Homicida Hospital 29a. Cartifiar 🗠 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to tha causa(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. (Check only one) within 2 To the 29b. Signature and litter of partifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 22118 who who plated causa of daath (Itam 23a) (Type, Print) 30. Name and address of pe Columbia Merc at start 11055 3 anus Made 1999^{32. Registrers Signatura}

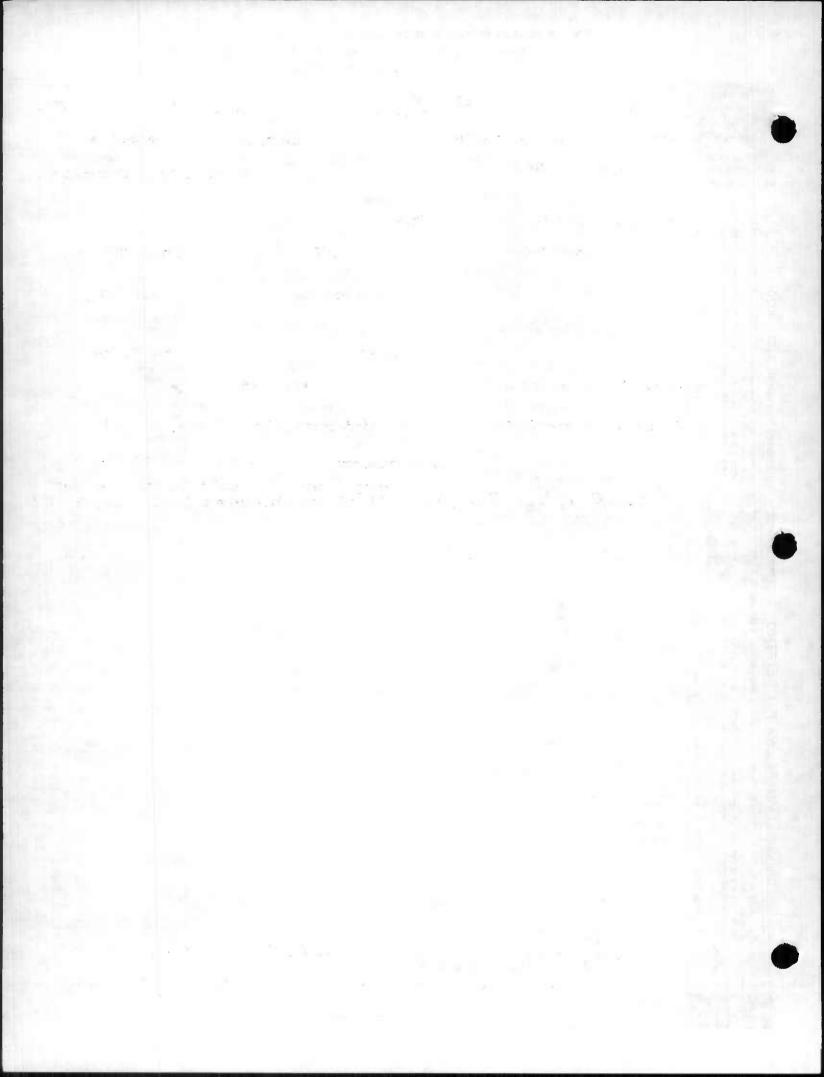
DHMH 16 Rev 6/95

State

Registrar

31. Data filed (Month, Day, Year)

0 FEB



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ITEMS: #1 PER MD #5 PER INFORMANT G771 5-21-99 WR. 1. Decedeni's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month **Physician** Harris Juy F. cornery 10 /Medical 4a Facility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Laurel Regional Hospital Prince George Laurel ff Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 578-20-9703 Birthplace (State or Foreign Country) 6. Sex 7. Aga (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 X M 2 □ F Yrs **Director** Apr 15, 1922 76 Washington, DC Usuel Residence of Dacedent 10d. fnside City Limits 10a, Stata 10b. County 10c. City. Town or Location r than "natural", or fleme 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 X No MD Howard Laurel Director 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 20723 USA 7805 Belgaro Road Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U.S. Armed Forcas? 14. Race - American Indien. 11. Marital Status Bleck, White, etc. 72 hours after 1 ☑ Yes 2 ☐ No
If Yes, Give
Yeer or Detes: 1942—45 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 ahould be filed within 7. Depertment of Health end Mentel Hyglena. Important: If Item 27 la marked other than "na any Injury or other traumatic event, the Meds. page. Washington, D.C. Elementery/Secondary (0-12) College (1-4or 5+) Superior Court Grade 12 Clerk of the Court 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Guy Franklin Harris Norma Lee Kolby 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) William Johnson /grandson 7822 Belgaro Road, Laurel, Maryland 20723 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 X Burial 2 Cramation 3 Ramoval from Stata Emmanuel Cemetery 2/13/99 Scaggsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signeture of Funerel Service Licensell Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Part1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. Unit only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Immediete Cause (Finel diseese or condition resulting in deeth) . Metastatic Squamous Cell Carcinoma of Lung /Medical Examiner Examin the burial-transit certificate be axecuted Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Ceuse (Diseese or injury that initialed avants rasulting In death) Last Due to (or es e consequence of): the attending physician end Box 68760. Physician/Medical Dua to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert t. 1 2 No 3 Probably 4 Unknown obstructive Lung Abscess Division of Vital Records, b 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed The lew 1 Yes 2 Och 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 28d. Describe how Injury occurred 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? edical Certification: Neturel 5 Pending Investigation 1 □ Yes 2 □ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signatura and title of certifiar 29c. License number February 254 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Moy 13952 Baltimore Ave Laurel Manyland 2070

DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Dey, Year)

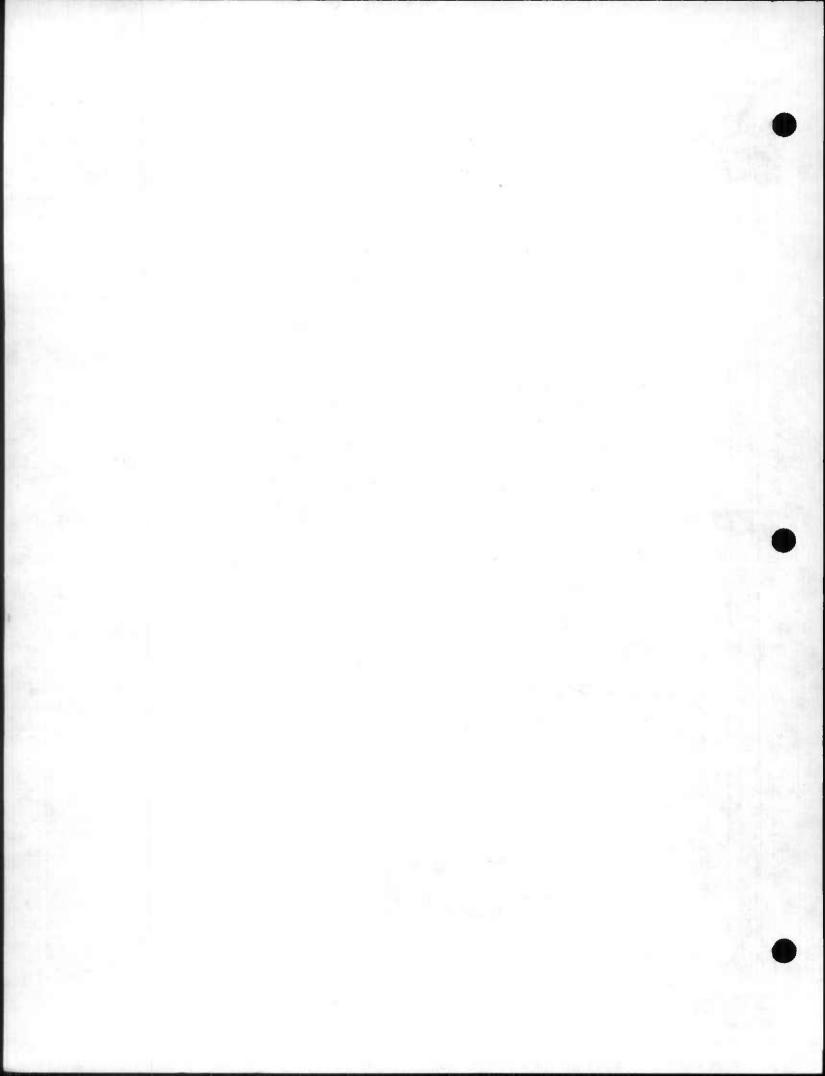
32. Registrar's Signeture

and of many concress.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Tima of Death 2. Dete of Death Day 24, 1999 Month **Physician** Holter George 10:45 AM January /Medical 4e Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Prince George's Regional Hospital Laure Laurel If Under 24 Hrs. If Under 1 Year 8. Data of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (Stete or Foreign Country) **Funeral** Days Months 1♥M 2□ F Hours Yrs. 214-10-4498 88 Director Aug 15, 1910 Maryland Usual Residence of Decedent with the Meryland 10b County 10c. City, Town or Location 10d Inside City Limits r than "natural", or items 23a or 28a-f show the Wedical Examiner must be notified at 1 ☐ Yes 2 No Director Prince George 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8613 Portsmouth Drive 20708 USA death Funeral 11 Meritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Datas: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry ified within 7 ! Hygiens. other than "n Etamantary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit.
Department of Heelth and Mental Phytiens important: if item 27 is marked other the any injury or other traumatic event, the 1 pages. Grade 12 State of Maryland Correctional Officer 17. Father's Neme (First, Middle, Last) 18 Mother's Nama (First Middle Maiden Sumama) Be George Millard Holter Bessie Kefauver 19e. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Sally Holter /spouse 8613 Portsmouth Drive, Laurel, Maryland 20708 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from State Christ Reformed ChurchCem 1/27 4 Donetion 5 Other (Specify) Middletown, Maryland 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 21. Signatura of Funeral Service Licens 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failurg. List only one cause on each line. Approximate Intervet Between Onset and Deeth **Physician** /Medical Immediate Cause (Final TACHYCARDIA . VENTRICULER diseese or condition rasulting in deeth) MINUTES Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last and Due to (or as e consequence of): ettending physician for use as the buria Box 68760 8 Physician/Medical Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. the 2 1 Yes 2 No 3 Probably 4 Number CONGESTIVE HEART FAILURE signed I Records. p 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Was an eutopsy performed? Completed peen page 2 has 2 No certificate 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital Physician: director, 25. Was case raferred to medical examiner? Be 26. Place of Death (Check only ona) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yes 2 No 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred Certification: 28c. Injury at Work? or Attending F saftar death. I Director: After d in by the funer After 1 Neturet 5 Pending 1 ☐ Yes 2 ☐ No 2 Accidant investigetion 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicida e Hospital o 24 hours aff e Funeral Di detely filled Ir 1 Certifying Physician: To tha best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred et the time, dete end place, end due to the cause(s) end manner stated. 29e. Certifier Medical pletely (Check only one) To the I within 2 To the I 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ichan Mo lih 1-24-1999 024011 30. Name end eddress of person who completed causa of death (Item 23a) (Type, Print) #700 SILVERSPRINGMD 20910 FENTON KHAN MD SAADULLAH 8630 31. Dete filed (Month, Day, Year) JAN 2 5 32. Registrat's Signature State back 1999 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 01/29/99 PCT Howard 2. Dete of Deeth **Physician** lerdisene 0830 A January 23 1999 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Nama (If not institution, give street and number) Examiner General Hospital Columbia County If Under 1 Yaar If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** Months Deys Hours 1 □ M 2 X F Yrs. Director 428-40-5445 May 11, 1927 Mississippi Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County 7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Medical Examples must be notified at 1 Yes 2 No Directo Maryland Howard Columbia 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5645 High Tor Hill 21045 United States Funeral filed within 72 hours after death 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14 Rece - American Indian Bleck, Whita, et 1 ☐ Yes 2 No If Yas, Giva Yeer or Dates: 1 ☐ Never Marriad 2 ☐ Married Black 1 Yes 2 No Specify: þ 3℃ Widowed 4 Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Hygiena. College (1-4or 5+) Elementery/Secondery (0-12) Homemaker Own Home permit. Pages 1 and 2 should be filled Department of Haalth and Mental Hygis Important: If Item 27 is marked other any Injury or other traumatic event, II 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Louis Young Easter Killingsworth 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Craig J. Harrington/Son 4634 14th Street North Arlington, VA 22207 Baltimore, 20e. Method of Disposition
1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 4 □ Donetion 5 □ Other (Specify) 2-3-99 Arlington, VA Arlington National Cem. 21. Signetura of Funerel Sarvice Licensee 22. Name and Address of Feeling Harry H. Witzke's Family Funeral Home, Inc. any ir Colo 23a. Pert1. Enter the disease, or complications that causad the daath. Do not antar tha mode of dying, such as cardlac or raspiratory arrest, shock, or heer feilure. List only one ceuse on each line. 4112 Old Columbia Pike Ellicott City, MD 21043 Approximete Intervel Between Onset end Death **Physician** /Medical Immediete Ceuse (Final disease or condition resulting in death) SEPSIS 3 weeks Examiner Due to (or es e consequence of): Physician/Medical Examiner 3 weeks PNEUMONIA certificata be axecuted ed by the attending physician and datached for use es the burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as e consequence of) Box 68760 Due to (or es e consequence of) 98 that the death 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. o 1 Yes 2 No 3 Probably 4 Unknown 0 OBSTRUCTIVE PULMONARY DISEASE Records, ð The law requires 24b. Were autopsy findings available prior fo 24a. Wes en eutopsy performed? Completed peen ULMONARY HYPERTENSION completion of cause hes certificate 1 Yes 2 NO No 1 ☐ Yes 2 ☐ No DIABETES MELLITUS Division of Vital Physician: 25. Wes case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Rasidance 6 Othar (Specify) ours after death.

neral Director: After this cr
y filled in by the funeral dire 1 Yes 2 No 2 1 ☑ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Certification: or Attending 1 Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours Hospitai edicai 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, daeth occurred et the time, dete end piece, end due to the ceuse(s) and menner stated. (Check only within 2 the 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Neme end eddress of persent who completed cause of deeth (Item 23e) (Type, Print) BERNARD P. FARRELL MD

32. Registrar's Signeture

JAN 23

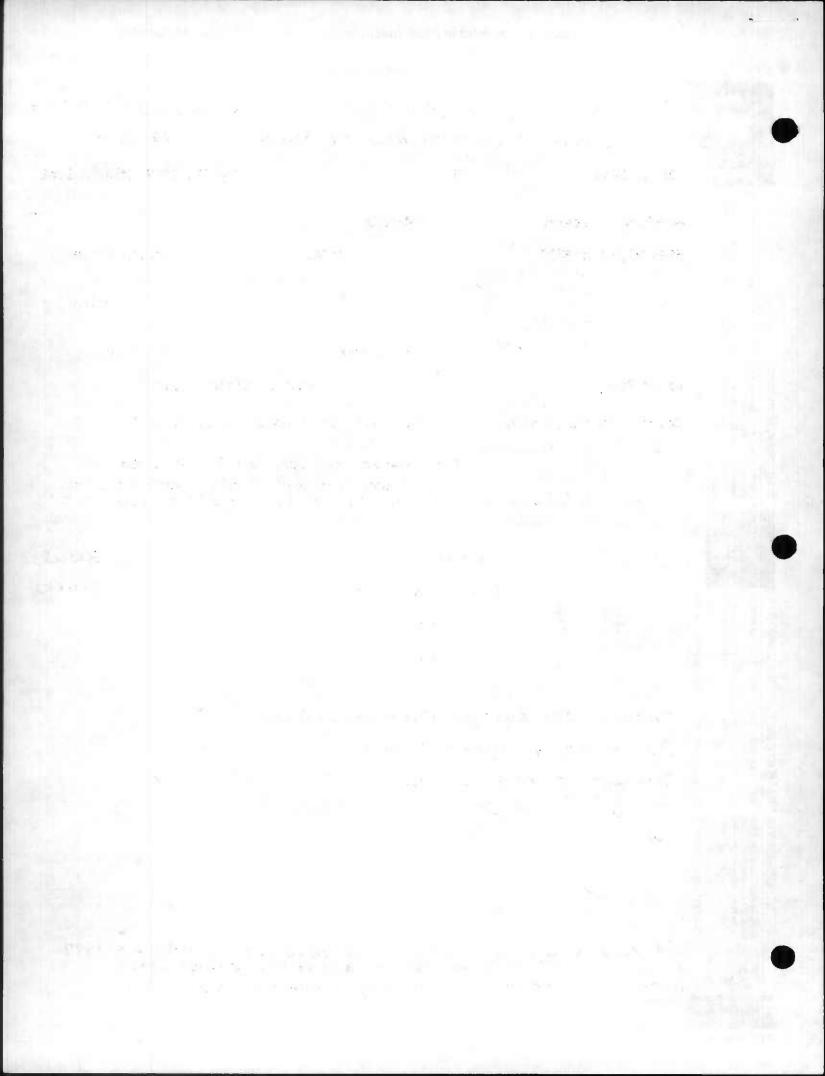
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PATUXENT PARKWAY, COLUMBIA, MD 21044

State Registrar 11055 LITTLE

31. Data filed (Month, Day, Year)

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 05 167

		Certificate	oi Dealli	Re	g. No.		
Physician	1. Decedent's Name (First, Middle, Last)			2. Date of Deeth Month	Day Year	3. Time of Dee	
/Medical	Walter Ronald Isaac, Sr.		The second	Jan.23		11:30	
Examiner	4a Facility Name (If not institution, give street and number) 737 Burrissville Road		eville Queen Anne's				
Funeral Director	217-50-8480 1980 2DF 5.	2 Yrs. If Under 1 \ Months D	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreig Country) June 30,1946 Maryland			
72 hours eiter death with the Maryland natural; or items 23s or 25s-1 show older Examerer must be notified at eted by Funeral Director	Usuel Residence of Decedent 10a. State 10b. County 10c. Ci	City, Town or Location				10d. Inside City Lir	
		Madison 10f. Zip Co				1 ☐ Yes 2 🔀	
	10e. Street and Number 1226 Taylors Island Road	21648	10	g. Citizen of What Co			
	11. Marital Status 1 □ Never Merried 2 □ Married 3 □ Widowed 4 ☑ Divorced 12. Was Decedent Ever in Userment Forces? 1 □ Yes ☒ ☒ No If Yes, Give Year or Dates:	If Yes, specify	of Hispanic Origin? (Sp. Cuban, Mexican, Puerton Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Ty		
natur Meal	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual C	Occupetion done during most of work	ina 1	6b. Kind of Business/	Industry	
then.	Elementary/Secondary (0-12) College (1-4or 5+)	Fire Fig	retired)	I	Anne Arur Co. #32	ndel Co.	
I to S	17. Father's Name (First, Middle, Last)			e (First, Middle, M			
s marked or numatic eve	Walter Earl Isaac			hy Mil			
27 le	19a. Informant's Name/Relationship (<i>Type</i> , <i>Print</i>) Lisa Konrad-Daughter		Street and Number or Rui Issville R				
nt: If itam iry or othe	1 Murial 2 □ Cremation 3 □ Removal from State	Plece of Disposition (Name cemetery, crematory or other thsemane Ch		27,199	Oc. Location - City or		
Department Important: any Injury pnce.	4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses	Cambridge, Md.					
Departm Importa any Inju pnce.	VIVIM ICHI	in & Ne	ewnam Fur	neral Ho			
	23a. Part1. Enter the disease, or complication that caused the dea shock, or heart failure. List only one cause on each line.	408 S.	Liberty S	or respiratory arre	ntreville	Approximate	
certificate be executed and moding physician end use as the buriel-transit and transit and		S ADENOCA (or as e consequence of): EVATIC To (or as a consequence of):	BONE	771 D LI	UER	eg druot	
g physic as the b	Cause (Disease of Injury C.	(or es a consequence of):					
ettending physic for use as the b	Cause (Disease of Injury that infiltated events resulting in death) Last Due to (d						
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ete hes been signed by the ettend page 2 should be deteched for us Completed by Physician	Cause (Disease or Injury that initiated events resulting in death) Last Due to (d		26. Plece of Dea	1 ☐ Ye	eutopsy 24b.	Were autopsy findir available prior to completion of cause of death?	
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Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended #5, 2/3/99, L.A.P., Queen Anne's Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Month JOSEPH PATRICK JUDGE, JR. Jan. 26,1999 2:05PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 300 Twin Ponds Lane Centreville Queen Anne's If Under 1 Year If Undar 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funerai** XXM 2□ F 577-56-5483 577-56-0483 Usual Residence of Decedent 57 Yrs. Director July 30,1941 Washington, D.C. death with the Marylend a or 28a-f show 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Queen Anne's Md. Centreville Director 1 ☐ Yes X☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r flems 23a o U.S.A. 300 Twin Ponds Lane 21617 by Funeral 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. "natural", or item filed within 72 hours after 1 ☐ Yes 27 No If Yes, Give Yaar or Dates: 1 ☐ Nevar Married 🏋 Married 21215-0020 1 ☐ Yes 2KNo Specify: White 3 Widowed . 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Glva kind of work done during most of working iifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Self-employed Elamantary/Secondary (0-12) College (1-4or 5+) Investor 12 5 trsumatic avent, altimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other treumatic event. 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Judge, Sr. Julia M. Altman Joseph Patrick 19a. Informant's Name/Relationship (Typa, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) P.O. Box 389 300 Twin Ponds Lane Centreville, Md. 21617 Donna L. D. Judge 1999 20c. Location - City or Town, State Jan. 27, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ② remation 3 ☐ Removal from Stata 5 ☐ Other (Specify) Stevensville, Md. 4 Donation Chesapeake Cremation Center 21. Signature of Funeral Service by 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 408 S. Liberty St., Centreville, Md. 21617 23a. Part 1. Enter Martin shock, or board all or complications that caused the death. Do not entar tha mode of dylng, such as cerdiac or raspiratory arrest, List only one cause on each loc. **Physician** Immediata Cause (Final disaase or condition resulting in daath) /Medical **Examiner** The lew requires that the death certificate be executed Sequentially list conditions, if any, laading to Immediata cause. Entar Underlying Causa (Disease or Injury that Initiated events resulting in daath) Last the burial-tran and Due to (or as a consequence of) Box 68760, attending physician for use es the buria Physician/Medical Due to (or as a consequence of): P.O. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? is certificate has been signed by t director, page 2 should be detect 1 Yes 2 No 3 Probably 4 Unknown Records, by Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? After this certificete has 1 Tyes 2 No 1 ☐ Yes 2 ☐ No of Vital Physician: Be 25. Was cese referred to medical 26. Placa of Daath (Check only ona) 1 Yes 2 No Other: 4 ☐ Nursing Homa 5 ☐ Residenca 6 ☐ Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred Division or Attending 5 Pending investigation 1 Natural death. 1 Yes 2 No 2 Accident within 24 hours efter deat To the Funeral Director: 3 ☐ Suicide 6 Could not be datarmined 28e. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 4 \ Homicida 29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, daath occurred at the tima, data and placa, and due to tha cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of cartifier 29c. License numbar 29d. Date signed (Month, Day, Year) 99

Registrar

State

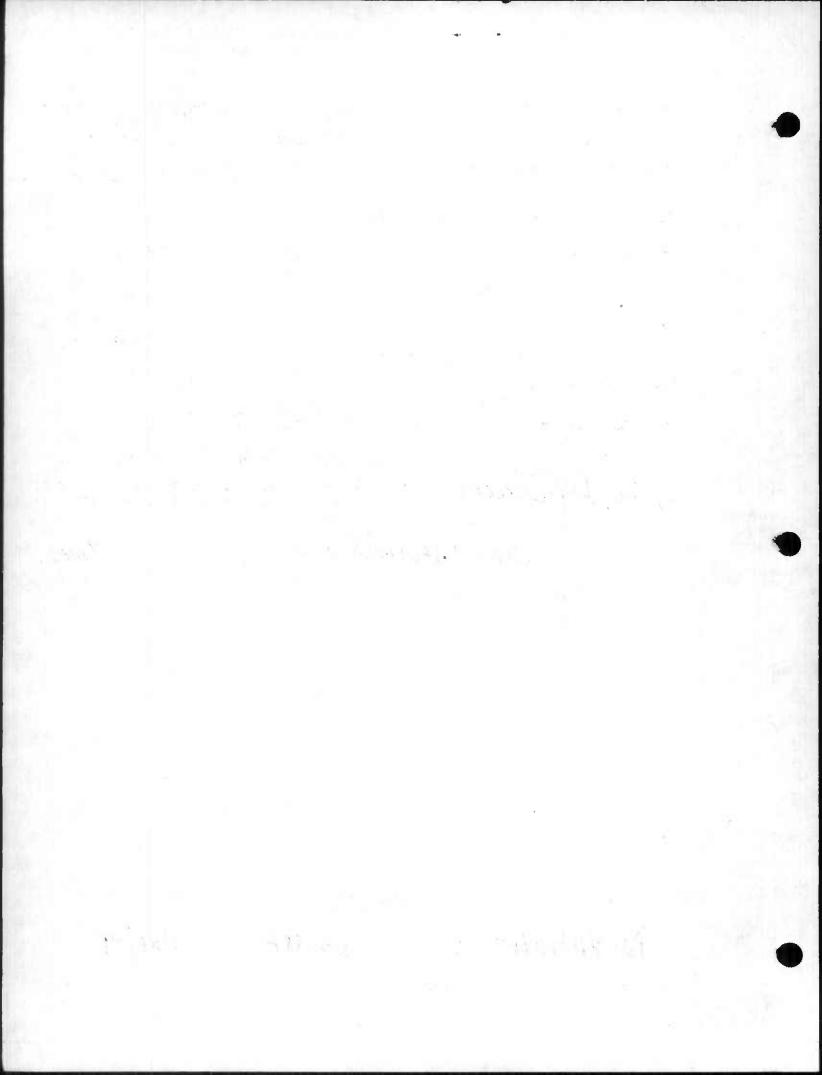
30. Name and addrass of person who completed cause of death (Itam 23a) (Type, Print)

IAN 2 8 1999

31. Data filed (Month, Day, Year)

David H. Smith, M.D.; 509 Idlewild Ave., Easton, Md. 21601

32. Ragistrar's Signatura



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle Last) 2. Deta of Deeth 3. Time of Death **Physician** Month Theodore Henry Kirkwood 11, 1999 February 4:20 am /Medical 4a. Fecllity Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Golden Oaks Nursing Home Laurel Prince George 5. Sociel Sacurity Number If Undar 1 Yaar | If Undar 24 Hrs. 7. Aga (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Hours 10XM 2□F 714-18-3195 Yrs. Director 86 1912 Pennsylvania Usual Residence of Dacedant the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. fnside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumetic avent, the Medical Examinar must be notified at MD Prince George Laurel 1 X Yas 2 No Director 10e. Street and Number 10f. Zip Coda 10g, Citizen of What Country? 9000 Briarcroft Lane #246 20708 USA Funeral 12. Was Dacedent Ever in U,S. Armed Forcas? 1 (ŽYas 2 □ No If Yes, Give Yaar or Detes: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien, Bleck, White, atc. 72 hours after 1 □ Nevar Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: White 3 Widowed 4 □ Divorced Completed Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 18b. Kind of Business/Industry filed within 7 Hygiena. College (1-4or 5+) Elementery/Secondery (0-12) Mechanic Automobile Dealership Grade pemit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 Is marked other any Injury or other traumatic avent. If 17. Fethar's Nema (First, Middla, Last) 18. Mother's Nema (First, Middle, Meiden Sumama) William Kirkwood unknown 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Childs /daughter 616 Carriage Hill Road, Melbourne, Florida. 32940 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Steta 1 ☐ Buriel 2 【Cremetion 3 ☐ Removel from Stete 2/11/99 Catonsville, Maryland Metro Crematory, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility
Donaldson Funeral Home, P.A. 21. Signeture of Funeral Service Licensus 313 Talbott Ave. Laurel, Maryland 20707-4389 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Betwe Onset and Deeth Physician /Medical Immedieta Ceuse (Finaf Metastatic carcinoma - brain 1 month disaese or condition resulting in deeth) Examiner Due to (or es a consequence of) Examiner Prostate carcinoma 9 years physician and s the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Diseasa or Injury that Initiated events resulting in deeth) Last Dua to (or as a consequence of): Box 68760 Alzheimer's dementia 4 years Physician/Medicai Dua to (or as a consaquance of): attending for use as P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by should be dated 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown chronic obstructive lung disease Records, þ Be Completed 24a. Wes an autopsy performed? 24b. Were autopsy findings evallable prior to completion of cause of death? page 2 : 1 Yes 2 No 1 Yas 2 No certificate Division of Vital l or Attending Physician: after death. 25. Wes casa referred to medical axaminer? director 28. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death 28a. Deta of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Neturel 5 Pending 1 Yas 2 No Invastigation 2 Accident Director: / 3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, ferm, streat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide within 24 hours a To the Funeral C completely filled Pelli Hospital 15 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated.

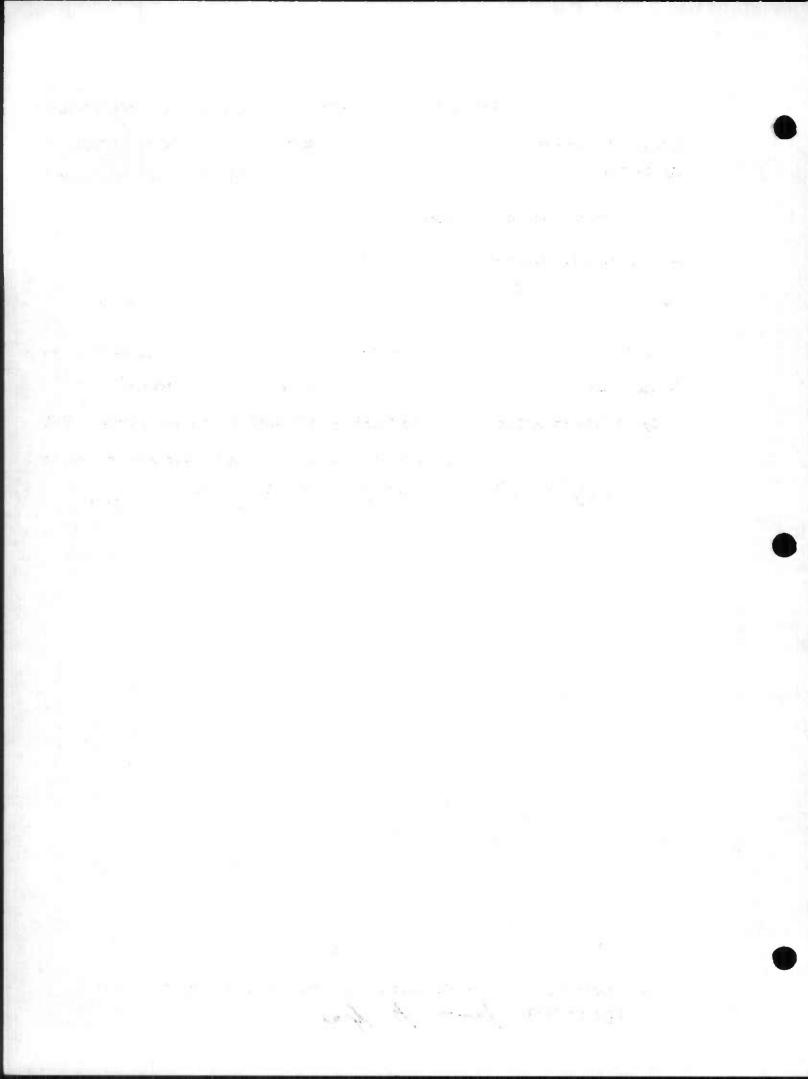
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29e. Certifies To the 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 6 . 11.9 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

State Registrar 31. Dete filed (Month, Dey, Year) FEB 1 2 1999

G. Manejwala,

32. Ragietrar's Signeture

14201 Laurel Park Drive, Laurel, Maryland 20707

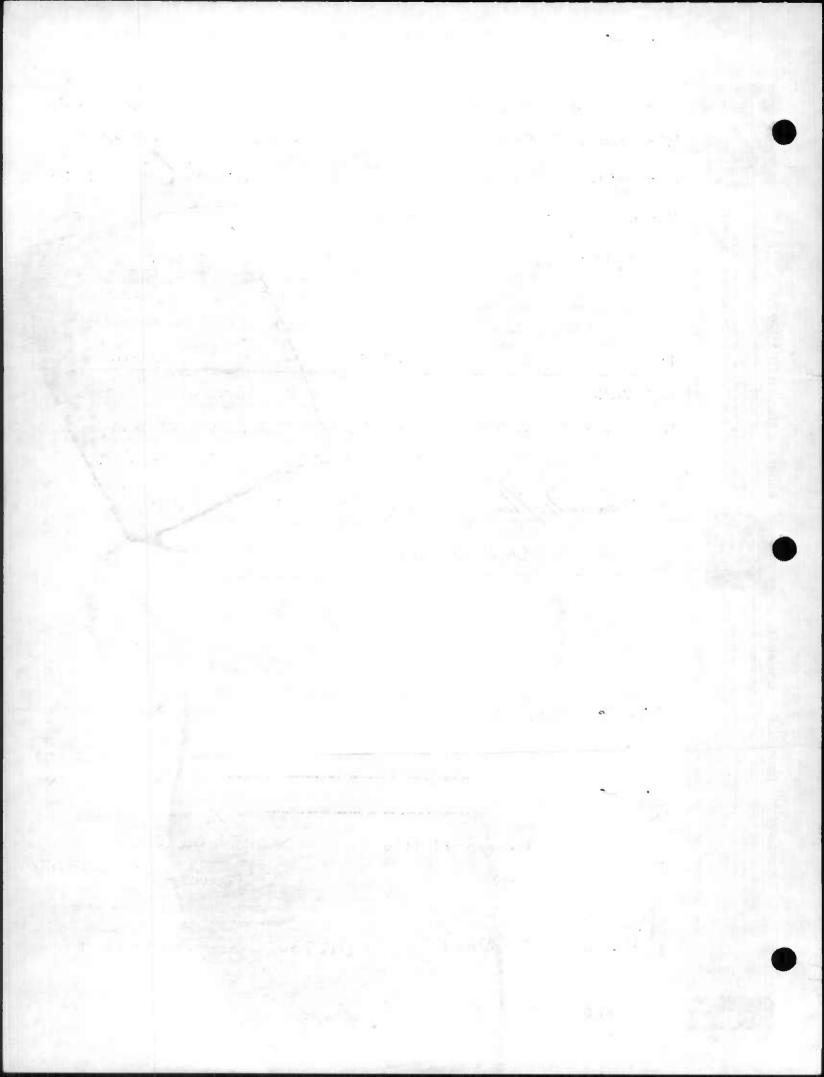


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Month **Physician** MHOE KLERE 8. 1999 1430 FEBRUARY /Medical 4a Facility Name (If not institution, give street end number)
45 COUSSE PACKNAT 4b. City, Town, or Location of Death 4c. County of Deeth Examiner ROCKULU MONTGOMERY 8. Date of Birth (Month, Day, Yeer) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) **Funeral** 1 M 2 □ F Months Deys Hours Min Yrs. 30 **Director** 575-76-9592 AUGUST 16,1968 WASHINGTON, DC Usual Residence of Decedent with the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Manjar nent of Haalih and Mental Hyglena.

Intel if the mark of other than "natural", or items 23a or 28a-f show mark of the traumatic event, the Madical Exprinent must be notified any or other traumatic event, the Madical Exprinent must be notified as MARYLAND 1™ Yes 2□ No MONTGOMERY ROCKVILLE Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20850 415 COLLEGE PARKWAY Funeral USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Maritel Stetus Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Yeer or Dates: Never Married 2 Married Specify: WHITE altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 STUDENT EDUCATION 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be 2 PAUL KLEBE CAROL JOHNSTON 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) CAROL JOHNSTON KLEBE-MOTHER 3600 WHISPERING LANE, FALLS CHURCH, VA 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or CREMATION CENTER CHANTILLY. VA 4 ☐ Donation 5 ☐ Other (Specify) 2/16/99 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility 1102 WEST BROAD MURPHY FALLS CHURCH FUNERAL HOME FALLS CHURCH, VA any 23a. Part1. Enter the disease, or comparations that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) DRUG-OUTROSE Examiner Due to (or es e consequence of): Examiner g physician and as the burial-transit certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or es e consequence of) esn Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? ed by the a SIP ROWIN TOLANTOCKUT 1 Yss 2 No 3 Probably 4 Unknown Division of Vital Records, à 24b. Were autopsy tindings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed page 2 s 188 certificata or Attending Physician: 25. Was case referred to medical exeminer?

Yes 2□ No Be 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 0 this funeral 28d. Describe how Injury occurred 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? Certification: After Injury 1430 1 Neturel 5 Pending investigation DRUG OUTROOSE s after daath. FEBRUARY 13 1999 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stele) U. T. Co. L. T. P. K. Y. OCKUNUS, M. filled in by 4 Homicide POCKVIUS, Hospital 24 hours 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

The dical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi edicai (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) ME FORWARY 13, 1999 30. Name end eddress of person who completed ceuse of deeth (Item 23a). (Type, Print) PIKE, BOCKVIlle, MT MArgolis 62. Registrar's Signature State 1999 Registrar MADC **DHMH 16 Rev 6/95**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death Month Yaar Physician 1999 30 MAE LOGAN 31 AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Have Ve Grace, H ir If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Fep 2.8 199 Hospilar Harkows HARFORD Mory If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foraign Country) 6. Sax **Funeral** 1 M 2 X F Months Days 226-30-6845 89 Yrs. **Director** Usual Rasidance of Decedant filed within 72 hours after death with the Maryland Hygiene. 10b. County 10a. Stata 10c. City, Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at HTYas 2□No Funeral Director Graco artoro 6 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda USA 811 Garfield 21078 12. Was Decedant Evar in U.S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status I ☐ Yas 2 No If Yas, Give Yaar or Datas: 1 Navar Marriad 2 Married BLACK 1 Yas 2 No Baltimore, Maryland 21215-0020 Specify. Specify: 3 Widowed 4 □ Divorced Be Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collaga (1-4or 5+) Domestic Hona makes 7 is marked other treumatic event, to 18. Mothar's Nama (First, Middla, Melden Sumama) parmit. Pages 1 and 2 should be filk Department of Haatth and Mantal Hy Important: If item 27 is marked other any Injury or other treumatic event 17. Fathar's Name (First, Middla, Last) Charlie FIAKE Lawerence 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 786 Everist KEDW. Koger 1 a Tuem 20a. Method of Disposition 20b. Place of Disposition (Name of camatary, cramatory or other placa) Data 20c. Locetion - City or Town, Stata Burial 2 Cramation 3 Ramoval from State
Donation 5 Other (Specify) James Com Havue dolorge o 22 Nama and Address of Facility Home D BCALD FURE ALL HOME 552 Lewis St Han 21. Signature of Funaral Sarvice Licansea Scot Grace, Havre Le 234. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Onsat and Death **Physician** Immediata Causa (Final disaasa or condition resulting in death) /Medical Examiner Physician/Medical Examiner SMOLA certificata be executed physician and is the burial-trans Sequantially list conditions, if any, taading to immadiata cause. Enter Undarfying Ceuse (Disaasa or Injury that initiated avants rasulting in daath) Last P.O. Box 68760. Dua to (or as a consequence of) 8 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. signed by d be datacl 1 Yes 2 No 3 Probably 4 Unknown þ Division of Vital Records, 24b. Wara autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed has No 1 Yas 1 Yas cartificate To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funeral Director: Aftar this cartifica complately filled in by tha funaral director, I 25. Was casa referred to medical axaminar? Be 26. Placa of Daath (Check only ona) 1 Yas 2 No Hospital: 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 ☐ Rasidance 6 ☐ Other (Specify) Mannar of Death 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Tima of Certification: 1 Matural 2 Accident 5 Panding invastigation 1 Yes 2 No 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not ba 3 Sulcida 28a. Place of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) 4 Homleide Dertifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Cartifier 29c. Licansa number 29b. Signatura and titla of certified completed cause of death (Item 23e) (Type, Print) 30. Nema and address of person who 1010 31. Data filad (Month, Day, Year) 32. Ragistrar's Signatura State Registrar **DHMH 16 Rev 6/95**

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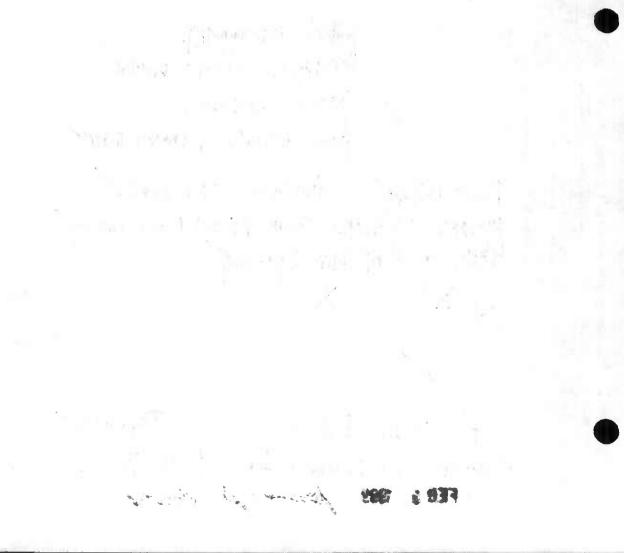
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Death 3. Tima of Death **Physician** John Lloyd Lay 1999 02 01 1127 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/13/1929 If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) MD 7. Age (In yrs. last birthday) **Funeral** 1)X) M 2 F Months Days Yrs. 69 Director 217-24-8630 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Norra 23e 1844 Pulaski Highway USA 21078 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 Never Married 20 Married 8 Maryland 21215-0020 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) of the state of th Elementary/Secondary (0-12) College (1-4or 5+) 11th Delivery Salesman J. Lawson Gilbert 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental 2 Christian LeRoy Lay, Sr. Helen Louise Hartenstine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elsie L. Lay- Wife 1844 Pulaski Hwy., Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 2/4/99 Perryville, MD Principio Cemetery 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Physician mediate Cause (Final sesse or condition sulting in death) Examiner leading to immedi Enter Underlying (Disease or injury by Physician/Medical DIMMINION 23b. Did tobacco use contribute to the cause of death? Unknown 1 Yes 2 No 3 Probably 24a. Was an autopsy 24b. Were autopsy findings available prior to Completed n of cause 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case / 80 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Passidence 6 Other (Specify) 1 Yes 2N No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manufact of De 1 Pageural 2 Actident 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending 1 Yes 2 No after deal Director: 6 ☐ Could not be 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 6 within 24 hours a To the Funeral S completely filled Sectiving Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated. | Sectiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier To the 296. Signature and title of certifier 29d. Date sigged (Month, Day, Year) 44 Name of person who completed cause of death (Item 23a) (Type, Prin um ATP Mun

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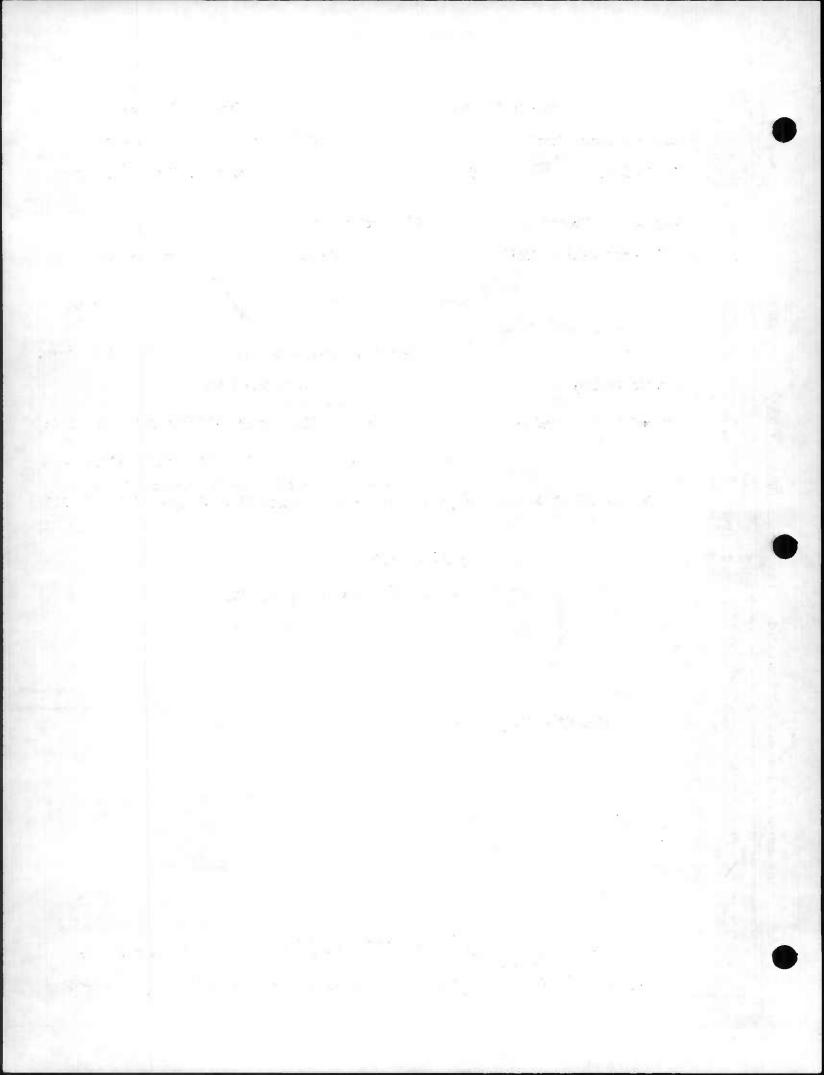


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State of Maryland / Department of Health and Mental Hygiene (

Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Raymond LaForge January 27 1999 9:25am /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner Lorien Nursing Home Columbia Howard Sex ⊁□ M 2□ F If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Yeer) 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Yrs. 083-10-1437 Nov 22, 1913 **Director** New York Usual Residence of Decedent the Marylend r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Directo Maryland Howard Ellicott City 10g. Citizen of What Country? 10e. Street end Number 10f, Zip Code than "natural", or items 23s or the Medical Examiner must be r 3521 Angus Valley Trail 21042 United States permit. Pages 1 and 2 should be filed within 72 hours after deeth very peartment of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a any injury or other treumatic event, the Maddel Examiner must once. Funeral 14. Race - Americen Indian, 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) Black, White, etc. 1 XYes 2 No If Yes, Giva Year or Dates: WWII 1 ☐ Never Married 2 ☐ Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐No Specify: þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) Collaga (1-4or 5+) Housing Superintendant New York City Govt. 18. Mother's Name (First, Middla, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Orville LaForge Susan Van Luven 19b. Mailing Addrass (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Ralationship (Type, Print) 3521 Angus Valley Trail Ellicott City, MD 21042 Raymond A. LaForge/Son 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 1-30-99 Catonsville, MD 21. Signature of Funeral Service Licensea 22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. em a 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each lina. Approximata Interval Batween Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) PNEWMONIA **Examiner** Dua to (or as a consaquance of): Examine POSSIB4 UNG CANCER physician end the buriel-transit the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Diseasa or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or es a consequence of): 88 usa Po ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown AZHEIMEN DISENTE signed to Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed After this certificate hes funaral director, paga 2 1 Yes 2X No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was cese raferred to medical examiner? Be 26. Placa of Death (Check only ona) Other: Nursing Homa 5 ☐ Rasidance 6 ☐ Other (Specify) 10 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Tima of Certification: 28a. Data of Injury (Month, Dey Year) 1 XNatural 5 Pending eftar death. Director: Aft 1 ☐ Yes 2 ☐ No Invastigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Streat end Number or Rurel Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) filled in by 4 Homleida 24 hours e 29a. Certifiar 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the ceusa(s) end manner es stated. edical To the Hosp within 24 ho To the Fune completaly fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier January 28, 1999 3 30. Name and address of pegion wi Guse of death (Item 23a) (Type, Print) m 5540 Thr
32. Registar's Signature CHARKVINE 31. Date filed (Month, Dey, Year) JAN 29 1999 Registrar

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month February 9, 1999 coation of Deeth 4c. County of Deeth Kenneth William Martin 2:05 P.M. 4a Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth Frederick Memorial Hospital | F100021 | Wonder 1 Year | Wonder 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 3, 1918 Frederick Frederick 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 15-M 20 F Yrs. 194-09-1584 80 Pennsylvania Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Frederick 1XX es 2□No Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 928 Shawnee Drive 21701 U.S.A. 12. Was Decedent Ever in U,S. Amped Forces? ‡\(\textit{Z}\)Yes 2 □ No If Yes, Give 1042-1945 Year or Dates 1942-1945 14. Race - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Co-Owner/ Store Paint Products 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Martin Charles Maride Ryan 19a. Intormant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 928 Shawnee Drive, Frederick, Maryland Mrs. Anna M. Martin, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematory, February 10, 1999 Smithsburg, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility Keeney and Basford P.A. Funeral Home 21. Signature of Funerel Service Licensee M00255 and 106 East Church St., Frederick, MD 21701 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last Due to (or as e consequence of): Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy tindings evelleble prior to 24a. Wes an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case reterred to medical exeminer? 26. Piece of Death (Check only one) 1□ Yes PENO Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

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/Medical Examiner

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Examinations in collections.

altimore, Maryland 21215-0020

2 Completed Be 10

edical

3 Suicide 4 Homicide 29a. Certifier (Check only one)

29b. Signeture p

8 Could not be determined

28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

Contifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and manner es steted. 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

mion who completed cause of death (Item 23a) (Type, Print)

William H. Jutween MD 187 31. Dete tiled (Month, Day, 32. Registrar' Signature

THOMAS JUHN SON DRIVE TREDERICE (M)

State Registrar

24 hours a Hospital

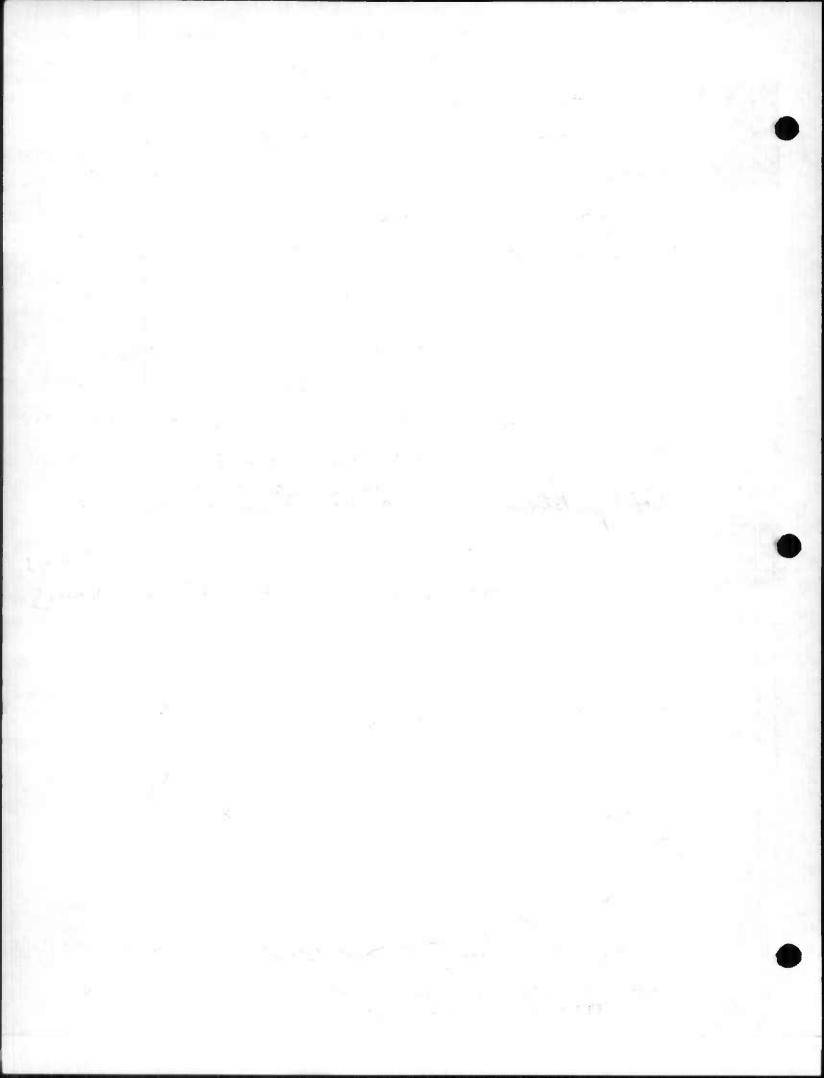
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 0145 m Marie Arbutus Murphy 02 /Medical 4a. Fecility Neme (If not Institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** Chesapeake Woods Center Cambridge Dorchester If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□ M 2XXF Days West Virginia Yrs 76 Director 214-10-0870 Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Hurlock YXYes 2 No Maryland Dorchester Director 7 is marked other than "natural", or items 23a or 28a-f traumatic event, the Medical Examiner must be notified 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? 61 Poplar Street 21643 US Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XX No Specify: White þ Specify: XXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specity only highest grade completed) 16b. Kind of Business/Industry pemit. Pages 1 and 2 should be fiad within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, the Ma Elementary/Secondery (0-12) College (1-4or 5+) Physical Therapist Aide Healthcare 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) William T. Reed Clara Marie Lahman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammy M. Jones Granddaughter 302 East Appleby Avenue Cambridge, Maryland 21613 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Junior Order Cemetery 2/12/99 Preston, Maryland 21. Signature Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a showly, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) ARKINSONS **Examiner** Examiner physicien end the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) the death certificate be execu Box 68760. Physiclan/Medical Due to (or as e consequence of) 80 attending signed by the atte P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ should should 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed 1 ☐ Yes 2 DANO 1 Tes Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred Certification: 28b. Time of 5 Pending investigation Natural 1 Yes 2 No 2 Accident filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Phyaician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

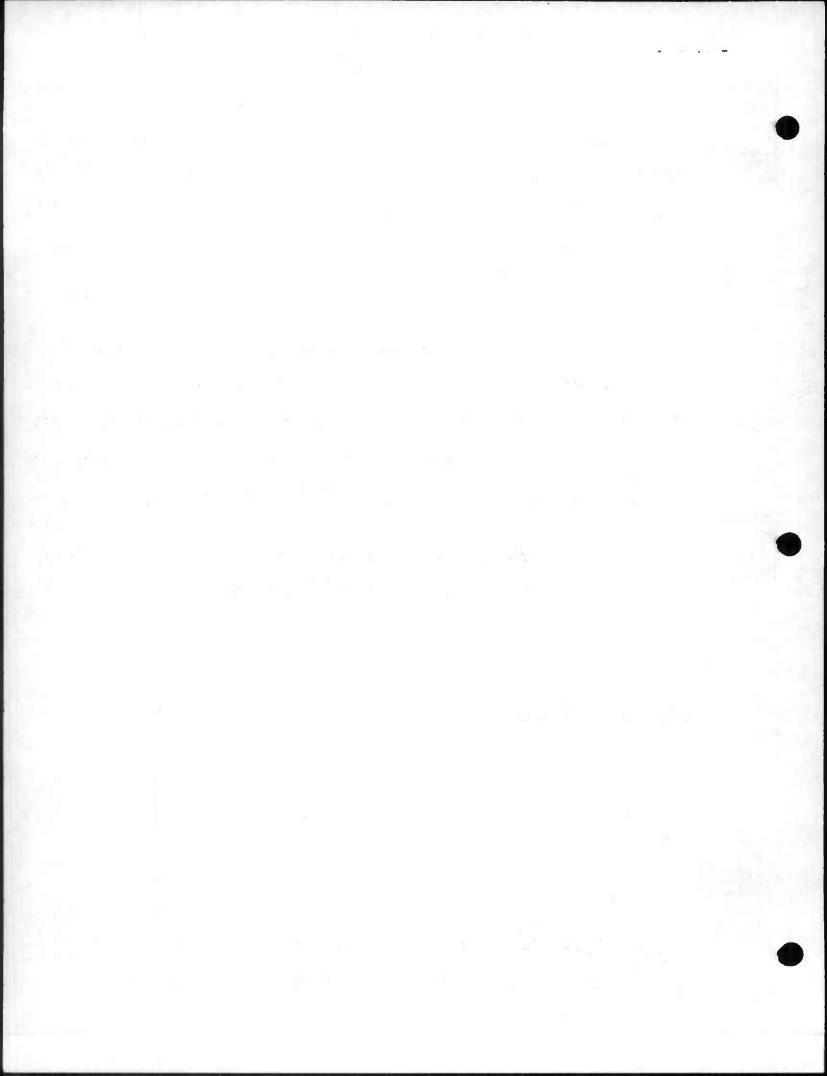


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na law requires that tha a has been signed by the aga 2 should be datache	his try of a	Icohol abu	se		24e. Wes en e	eutopsy 24b. 1	Were eutopsy find

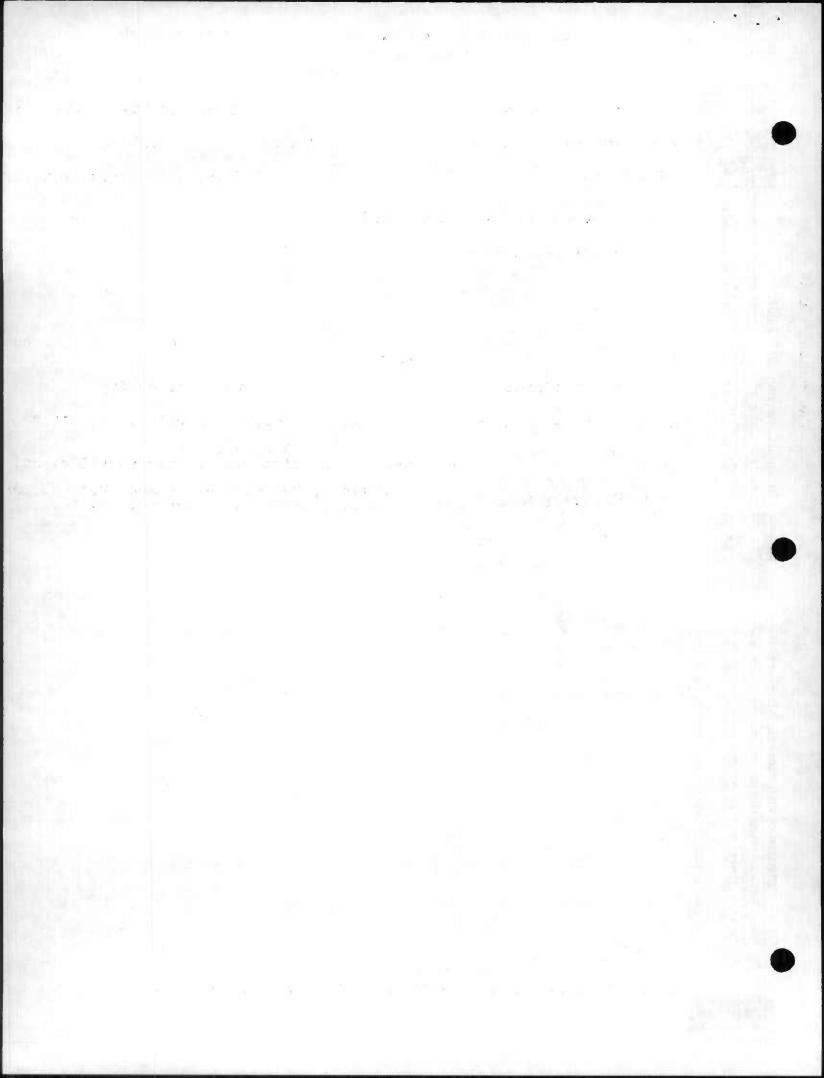
State

Registrar

Kathleen Hoey, M.D.; 2540 Centreville Rd., Centreville, Md. 21617
31. Dete filed (Month, Day, Year)
32. Ragistrey's Signeture 31. Dete filed (Month, Day, Year) JAN 2 5 1999

30. Neme and eddress of person who completed ceuse of daeth (Itam 23e) (Type, Print)

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Data of Daath Month Day Year MILDRED CECIL MURPHY Feb.3, 7:50PM 1999 4c. County of Deeth 4a Fecility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death Chestertown Kent Tammy's Home If Under 24 Hrs. Hours Min. 5. Social Sacurity Number 214-74-2455 If Undar 1 Year Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Months Days 1 □ M 280 F 92 Yrs. Sept.20,1906 Mary land Usual Rasidanca of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits Chestertown Kent Yes 2□ No 10c. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 21620 205 Washington Avenue U.S.A. 12. Was Dacedant Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☑No If Yas, Giva Was Dacadant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indien, 11. Marital Status Black, Whita, atc. 1 ☐ Never Married 2 ☐ Merrled 1 ☐ Yas 2 ☑ № Specify: Specify: White 3 □ Voldowed 4 □ Divorced Year or Datas: 16a. Decedant's Usual Occupetion (Give kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada complated) Collega (1-4or 5+) Elementary/Secondary (0-12) Self Homemaker 18. Mothar's Nama (First, Middla, Maiden Sumama) 17. Fathar's Nama (First, Middle, Last) Dollie Virginia Walls Harry Milton Cecil 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. tnformant's Name/Ralationship (Type, Print) P. O. Box 297, Edgewater, Md. 21037 Marvin A. Cecil (Brother) 1999 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20e. Method of Disposition Feb. 1 X € Frial 2 Cremation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Church Hill, Md. Church Hill Cemetery 22. Nama and Addrass of Facility 21. Signeture of Funeral Sarvice Licensas Fellows, Helfenbein & Newnam Funeral Home Cheew! 408 S. Liberty Street, Centreville, Md. 23a. Pentl. Enter the/disaesa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiretory errest, shock, or head failure. List only one cause on each life. Approximete tntarval Batween Onset end Death Immadiata Causa (Final disease or condition rasulting in death) VACUTE CUA 246215 Sequantially list conditions, if eny, leading to immediate causa. Entar Undarlying Ceusa (Disease or Injury that initiated avants resulting in daath) Lest Dua to (or es e consequança of): Due to (or as a consequanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

10a Stata

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Md.

Director

Funeral

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Completed

Be

Funeral

Director

permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Marylend Deportment of Health end Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Exercises must be notified as once.

Baltimore, Maryland 21215-0020

Examiner physician end s the buriel-transit Physician/Medical 80 attending p signed by the a by s need should Completed his certificate has b Be Certification: To this After this funeral of death.

The law requires that the death certificate be executed

or Attending Physician:

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within 24 hours efter death To the Funerel Director: / completely filled in by the

Division of Vital Records, P.O. Box 68760

24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

		1 Yas 2 No 1 Yas 2 No				
25. Was casa rafarrad to medical	26. Placa of Daati	h (Chack only ona)				
axaminar? 1 □ Yas 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	ma 5 Rasidanca 6 Mothar (Specify)				
27. Manner of Death 1 Neturel 5 Pending 2 Accidant invastigatio	(Month, Day Year) Injury Work?	28d. Describe how injury occurred				
3 Sulcida 6 Could not be determined		281. Location (Straat and Number or Rural Route Number, City or Town, State)				

29a	(Chi	ock of	nly
	-		-

1 Certifying Physicien: To the best of my knowledge, death occurred et tha tima, dete end plece, end due to the causa(s) and mannar es stated.

2 Medical Examtner: On the besis of axaminetion end/or investigetion, in my opinion, death occurred et the tima, date and plece, and due to the cause(s) end mannar steted.

29b. Signatura and titla of cartifiar ney 29c. Licansa number

29d. Date signed (Month, Day, Year)

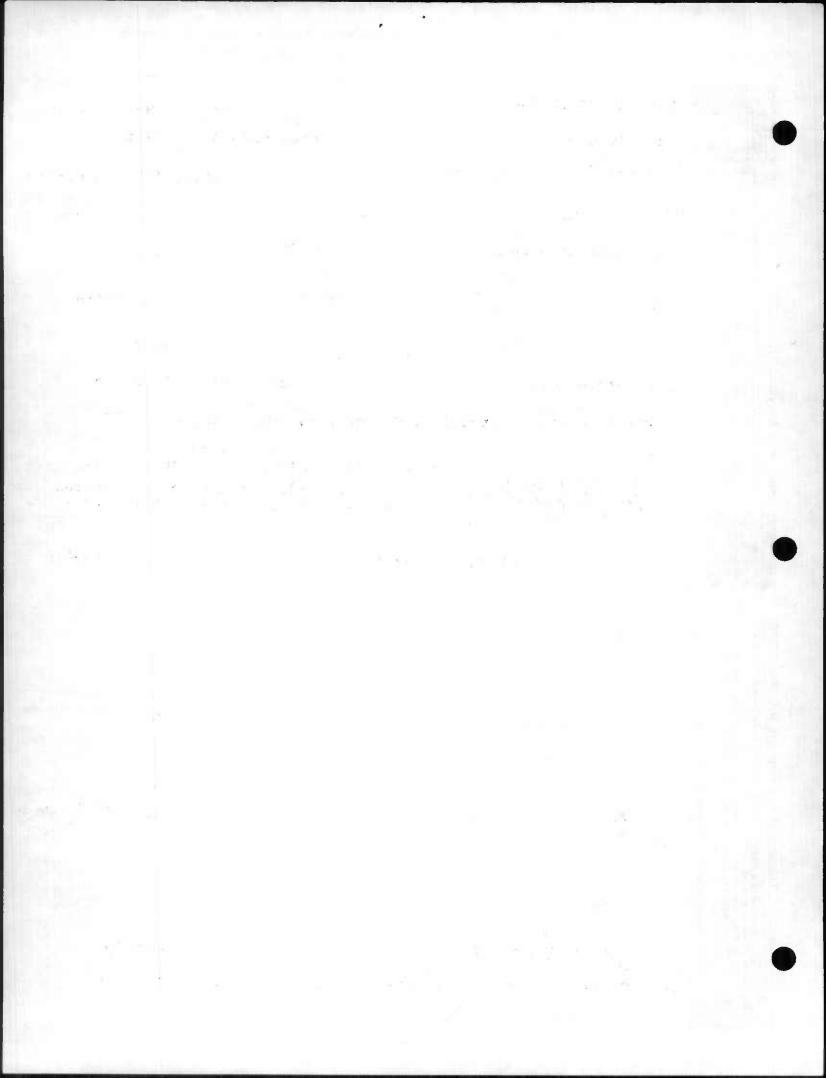
9-132-24

30. Nama and accrass of person who complated causa of death (Item 23a) (Type, Print)

John C. Seymour, M.D.; 122 Speer Road; Chestertown, Md. 21620

State Registrar 31. Defe filed (Month, Day, Year) 32. Ragistrar's Signatura FEB 0 5 1999 >

Sporker



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	3 ☐ Widowed 4 ☒ Divorced If Yes, Give Yeer or Detes:					1 ☐ Yee 2 No Specify:						Spec	Specify: White		
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	1 ☐ Burial 2 €					latro	_			12	/9/99	Catons	ville.	Maryl	ar
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	21. Signeture of Funeral Home, P.A. 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389												20		
	23a. Pert1. Enter the shock, or hee	e diseana,	or compl	cations thet co	aused the d	eeth. Do no							110 207	Approximate	
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n ys	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco									Yes 2 No	Use contribute to the cause of death ☑ No 3 ☐ Probably 4 ☐ Unknow				
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5	 Menner of Deeth Naturel 	5 ☐ Pend	ling	26a. Dete o (Monti	of injury h, Dey Year	28b. Tir	ury	28c. Injui Wor			28d. Describe	how injury occu	urred		
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	29e. Cartifler	1D Contes	ing Phic	alalan. Ta the	hast at !	moude 4- c	death	and as should		-las-	mal alue to the	annative et			
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Ž	29b. Signeture end	title of periffs	er /	7 . /	A.			29c. Licens	e number			29d. Dete sign	ned (Month, L	Day, Year)	-
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State Registrar

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Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at 2006s.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

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er e degrad ter

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 1999 February | 1999 cation of Death Gc. County of Death 0638 MARY IRENE NOOFT 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Fallston Fallston General Hospital Harford If Under 24 Hrs. 8. Date of Birth (Month, Dex Year) 6/11/1932 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex Birthplace (State or Foreign Country) Months Days 1□M 200F 216-28-7170 Virginia 66 **Usual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No (Black Horse) Md. Harford White Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4321 Norrisville Road 21161 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 0 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Caucasian 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lowell Thompson Ruth Bruce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn F. Price/Daughter same as #10 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 275 1 Denation 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bel Air Mem. Gardens 1999 Bel Air. Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E.G. Kurtz & Son Funeral Home. P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on order line. Approximata Intarval Betw Onset and Death FAILURE Immediate Cause (Final disease or condition resulting in death) WEEK Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contributs to the causs of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Division of Vital Records, 看 After Attending d or Attending after death. Director: After

Physician

Medical

Physician

/Medical

Examiner

Director

Funeral

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylen Department of Health end Mental Hygiena. Important: if item 27 is marked other than "natural", or hems 23s or 25s-f show any brighty or other traumatic evant, the Medical Exemples must be notified at once.

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Physician/Medical Completed Be Certification:

Medical

1 Yes 2₽ No 27. Mannge of Death 1 (DNatural 5 ☐ Pending

29a. Certifier

investio 2 Accident 3 ☐ Suicide 4 ☐ Homicide

6 ☐ Could not be

28a. Data of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 | Yas 2 | No 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.

iner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to tha cause(s) and manner stated. ture and title of certifie

29c. Ligense number

29d. Date signed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

State Registrar

32. Registrar's Signature

To the Koepital o within 24 hours at To the Funeral Di completely Illied in

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Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 30,19 2042 ABDULLAH NAEIMI JANUARY 4c. County of Death 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death LAUREL HOSPITAL PRINCE GEORGES LAUREL REGIONAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) Months Deys 1 X M 2□ F 219-21-5070 32 Mar 05, 1966 Iran Usual Residence of Decedent 10c. City, Town or Location 10d Inside Clty Limits 10h Counts 1 No Yes 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 13908 Castle Boulevard #101 20904 Iran Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ✓ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Middle Eastern 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Collage (1-4or 5+) 2 years Elemantary/Secondary (0-12) Student College 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Badredin Naeimi Nahid Chini 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Numbar or Rural Route Number, City or Town, State, Zip Code) Alireza Chini /uncle 3145 Fairland Road, Silver Spring, Maryland 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 2/2/99 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cem. Adelphi, Maryland 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart lajitud. Let only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final . HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in death) RENAL FAILURE CHRONIC Sequentially list conditions, if any, leeding to immediate cause. Entar Underlying Causa (Disaasa or injury that initiated events resulting in daath) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown SEIZURE DISORPER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy DIABETER MELLITUS performed' 1 ☐ Yes 1 ☐ Yes 2 No 25. Was casa rafarrad to madical examiner? 26. Place of Death (Check only one) examiner? 1 XYes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 XER/Outpetient 3 ☐ DOA

Physician /Medical Examiner

Important: If its any injury or oth

Physician

/Medical

Examiner

10e State

Funeral

Director

"natural", or items 23s or 28s-1 show

7 is marked other than "nature traumatic event, the Modical

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Director

Funeral

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Completed

the Maryland

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filed within 72 hours efter Hygiene.

Baltimore, Maryland 21215-0020

Examiner The law requires that the death certificate be executed physician and the buriel-transit Physician/Medical for use es signed by the a p Completed peed Be

certificate has t lirector, page 2 s or Attending Physician: director this After thi death. Director: A hin 24 hours aft the Funeral DI npletely filled in

Division of Vital Records, P.O. Box 68760.

30. Nama

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Certification:

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27. Mannar of Death

1 MNatural

2 Accident

3 Suicide

29a. Certifier

4 Homicida

State Registrar

5 Pending

investigation

6 Could not be

29b. Signature and title of certifier

28a. Data of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Spacify)

29c. License number

1 Yes 2 No

1 Certifying Physician: To the best of my knowledga, death occurred at the tima, data and place, and dua to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, data and place, and dua to the cause(s) and mannar statage. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

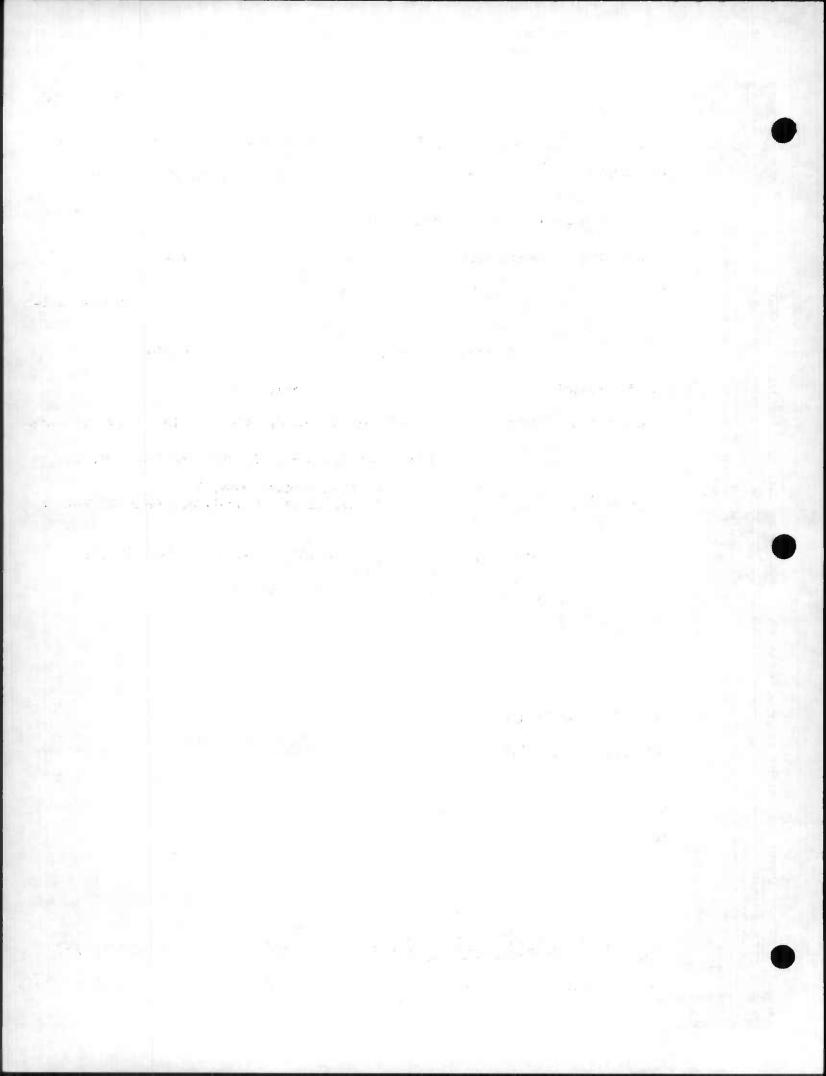
28d. Describe how injury occurred

oausa of death (Item 23a) (Type, Print) = GOLLE PRIVE, QUEVERLY MARYLAND 20785 HOSPITAL MP 3001 31. Dete filed (Month, Day, Year)

28c. Injury at Work?

32. Raguerar's Signatura FEB 0 3 1999

within 2 To the



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 3:00 PM Niemann dugva /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number, Examiner 4800 C OVIEG Warsing (olumsia HOWGVON If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day Par) 5. Social Security Number 8. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 90 Months **GEOMETRY** 1**X)**M 2□ F 154 30 9013 Director Usual Residence of Deceden the Maryland 10b Count 10e State 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Departmant of Health and Mental Hyglena. Important: if Itam 27 is marked other than "natural", or hama 29a or 28a-f show any Injury or other treumstic event, the Medical Examinar must be notified at Md Mantgarery 1 Yes 2 No Rockville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20853 14643 Bauer Dr. # 211 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Bleck White Lets 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Detes: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
Minister

Minister 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Clergy Elementary/Secondary (0-12) 12 College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 Mary Ward Wilhelm Niemann 10 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 807 Norwood Rd. Silver Spring Md. 20904 19a. Informant's Name/Relationship (Type, Print) Rolf Niemann/SON 20a. Method of Disposition 20b. Place of Disposition (Name of George cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/08/99 Washington DC Washington Univ. Med. Ctr 4月Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Columbia Mortuary Services neral Service License PO Box 58007 Washington DC 20037 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Benenth Examiner Examine ettanding physician and for usa es the buriel-transit The law requires that the deeth certificets be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760, Physician/Medical Due to (or as a consequence of): 0.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1-10s 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed hes this cartificata 1 Yes 2√ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 89 26. Place of Death (Check only one) Other: ABNursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Medical Certification: To After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred To the Hospital or Attending PI within 24 hours after death.
To the Funeral Director: After the complishely filled in by the funeral 28b. Time of 28c. Injury at Work? 1- Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one)

State Registrar

29b. Signature and title of certifie

30. Name and address of person why

31. Date filed (Month, Day, Year)

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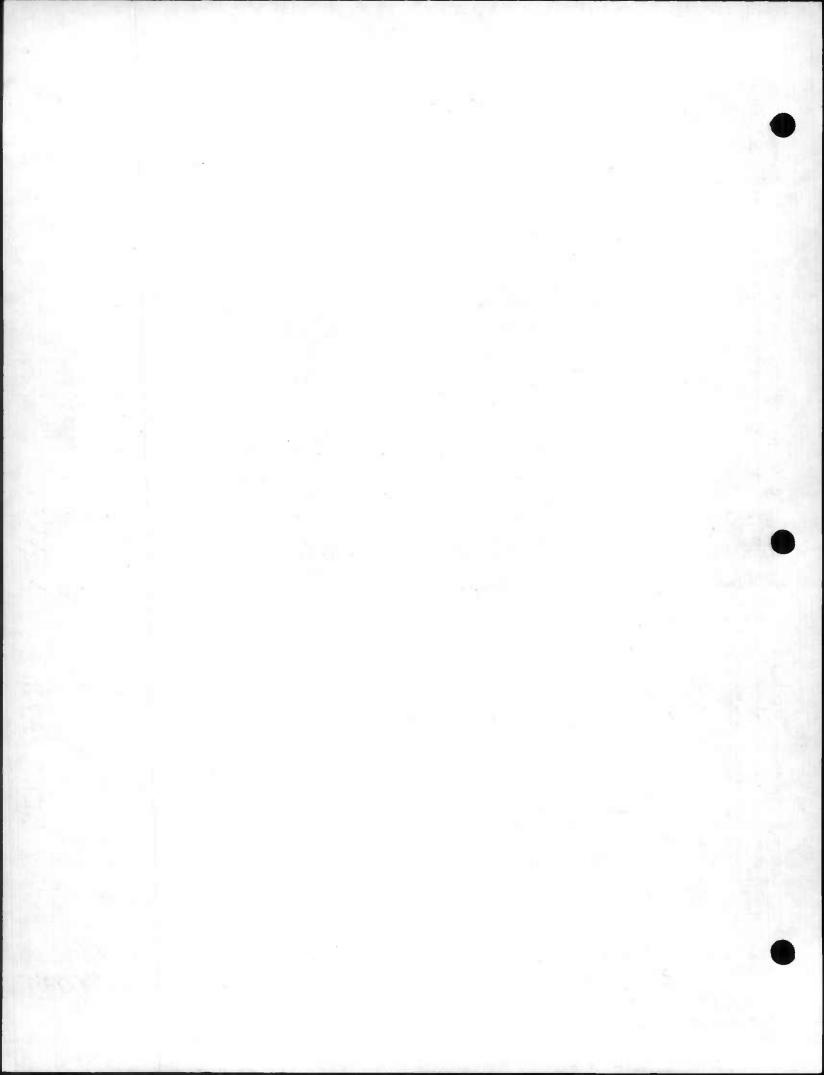
completed cause of death (Item 23a) (Type, Print)

32. Registrer's Signature

0805

29c. License number

29d. Date signed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** February 5, 1999 1:15 P.M. MILDRED JOHNS OGLE /Medical 4b. City. Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner 1417 Creswell Road Aberdeen Harford If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 10 M 20 F Yrs. Oct. 6, 1924 Director 217-12-8253 Maryland Usual Residence of Decedent should be filed within 72 hours efter death with the Merylend of Mentai Hygiene.

marked other than "natural", or frems 23s or 28s-f ahow 10d. Inside City Limits or 28a-f ahow 10a State 10b. County 10c. City, Town or Location 1 Yes 2 No Director Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23s or traumatic event, the Medical Examiner must be a 21001 USA 1417 Creswell Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ZetNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 3 ☐ No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Printing Secretary permit. Pages 1 and 2 should be filed.
Department of Health and Mental Humbortant: if item 27 is master any injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (u/k)White (u/k)Johns Anna John 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dorman N. Ogle, Sr. - Husband 1417 Creswell Road, Aberdeen, Maryland 21001 20b. Pleca of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 2/8/99 Baltimore, Maryland 21. Signature of Funeral Servica Licenses 22. Name and Address of Fecility Howard K. McComas III Funeral Home, P.A. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, k, or heart failure. List only one class on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner ettending physician end for use es the bunel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical 23b. Did tobacco use contribute to the gause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? been si should 24a. Was an autopsy Completed hes e 2 certificate her 1 Yes 2 M 1 ☐ Yes 2 ☑ No Hospital or Attending Physician: 25. Was case referred to midical examiner? director Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☑ Desidenca 6 ☐ Other (Specify) 2 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending Investigation 1 Matural 1 Yes 2 No death. 2 Accident Director: 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide To the Mospital or within 24 hours eff To the Funeral DI completely filled in 10 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and menner stated. edicai 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

· D. - 104 PLUMTREE RD. BEZ

State Registrar 31. Date filed (Month, Day, Year)

FEB 8

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al .

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dev Veer **Physician** 9:55 AM February 6,1999 Eileen O'Connor Margaret /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Name (If not institution, give street end number) Examiner Harford 7 E. MacPhail Road Bel Air 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In vrs. last birthday) 6. Sex 8. Date of Birth (Month, Dey, Year) **Funeral** Min. Deys Months Hours 1 ☐ M 2 ☐ F 61 219-32-8360 Director Mar. 28, 1937 Maryland Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City. Town or Location 10d Inside City Limits 7 is marked other than "natural", or itsms 23a or 28a-f show traumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 TNo Bel Air Director Harford Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21014 USA 7 E. MacPhail Road Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Marital Status 1 Never Married 2 ☐ Merried Specify: White Maryland 21215-0020 1 ☐ Yes 25 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Certified Nursing Assistant Home Health Care 12 permit. Pages 1 end 2 should be filed.
Department of Health and Mental Hygi Important: If Item 27 is marked other any Injury or other traumment. 17 Fether's Name /First Middle Lest) 18. Mothar's Neme (First, Middle, Maidan Sumame) Be James Arthur O'Connor Tierney Margurite Mary 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stata, Zip Coda) 19e. Informent's Name/Reletionship (Type, Print) Jerome W. O'Connor / Brother Route 1 Box 122-A12, Keyser, West Virginia 26726 Baltimore, 20b. Place of Disposition (Nema of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition p☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 2-9-99 Havre de Grace, MD Mt. Erin Cemetery 5 Other (Specify) 21. Signeture of Fu 22. Name end Address of Fecility erel Service Licenses Howard K. McComas III Funeral Home, P.A. 50 W. Broadway St., Bel Air, MD 21014 23a. Pert. Enter the disease, or complications that classed the dishock, or heart failure. List only one cause on as a line. Do not enter the mode of dylng, such as cardiac or respiratory errest. Approximete Intervel Between Onset end Death **Physician** METASTANC ADENOCARCINOMA 8 MONT7+S /Medical tmmediate Ceuse (Finel disease or condition rasulting in death) Examiner Examiner physicien end the buriel-transit Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disaasa or Injury that initieted evants resulting in deeth) Lest Due to (or es e consequence of): certificete be exec Box 68760. Physician/Medical Due to (or es e consequance of) 98 USA ŏ signed by the eld be deteched for 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Àq 24b. Were autopsy findings eveilabla prior to completion of cause of daath? 24a. Wes en eutopsy performed? Completed peen pege 2 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes certificate Hospital or Attending Physician: director. 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Be Othar: 4☐ Nursing Home 5 Presidence 6 ☐ Other (Specify) 2 No 2 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred Certification: 28b. Time of After 5 Pending investigation 1 Naturel efter death. Director: Aft 2 No 1 Yes 2 Accident 3 Suicide 6 Could not be 28f. Location (Streat and Number or Rurel Route Number, City or Town, Stete) Place of Injury - At homa, ferm, streat, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours e ertifying Physician: To the best of my knowledga, daath occurred et the time, dete and plece, end due to the causa(s) and mannar es steted.

Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner stated. 29a. Cartifiar To the Hosp within 24 hou To the Funer completely fil Medical 29d. Date signed (Month, Dey, Year) and title of ceruser 29c. License number 29b Signature

State Registrar 31. Date filed (Month, Day Year) 32. Registrer's Signeture

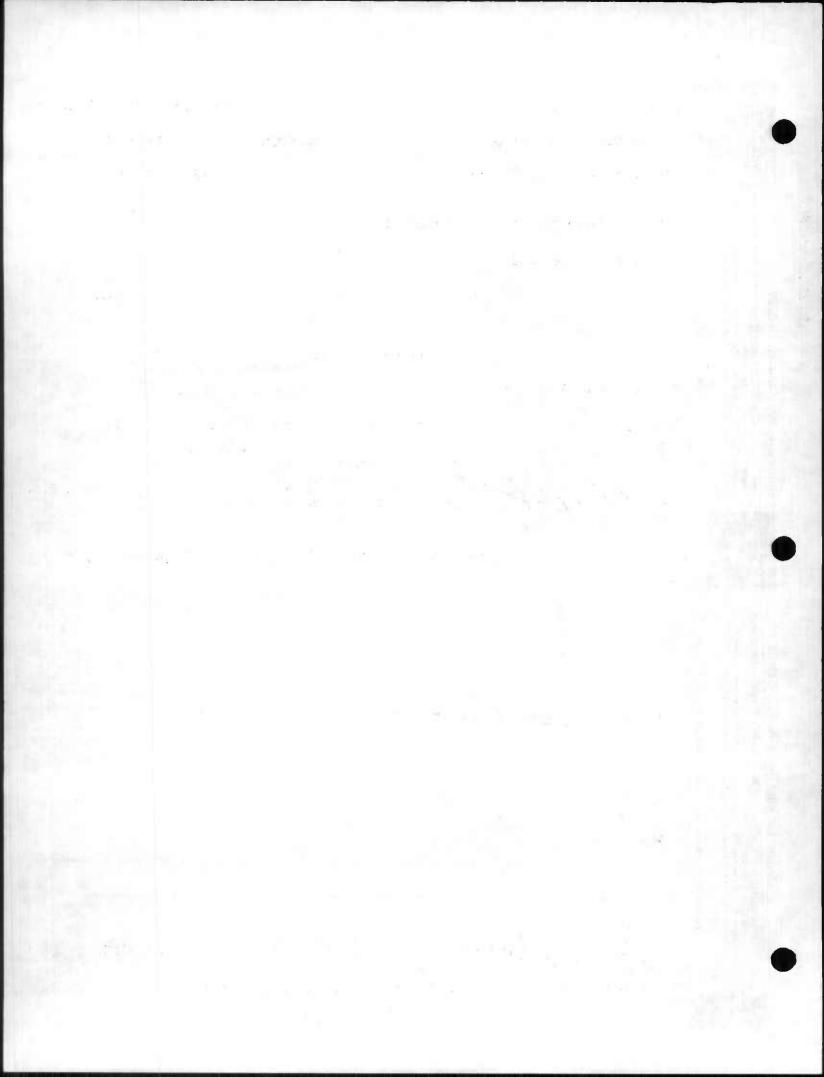
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State of Maryland / Department of Health and Mental Hygiene 0 0 5

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Registrar

State

harlest. Wright II MD 9000

32 Registrar's Signature

31. Date filed (Month, Day, Yee) FEB 3 1999

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Ella Cecilia Parker 01 25 1999 2155 4e Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace Hartord If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours Days Months 1 ☐ M 2 🕱 F Yrs. 87 216-16-2223 5/30/1911 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 720 Green Street USA 21078 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Married 1 Yes 2 XNo Specify: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wright Price Rose Ella Baldwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James C. Smith-Son 720 Green St., Havre de Grace, MD 21078 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 \ Burial 2 \ Cremation 3 \ Removal from State 4 \ Donation 5 \ Other (Specify) Angel Hill Cemetery 1/29/99 Havre de Grace, MD 22. Name end Address of Facility Mitchell-Smith Funeral Home, P.A. 21. Signature of Funeral Service Licensee 123 S. Washington, Havre de Grace, MD 21078 23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that instead executions) Due to (or as a consequence of) that initieted events resulting in death) Last Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes Q No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide The contitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Division affa 6 24 hours Funeral

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be nothed at

72 hours after

d 2 should be filed within 72 th and Mental Hygiene. 7 Is marked other than "nu

Pages 1 and 2 should

Department of Health Important: If Item 27 I

Physician /Medical

Examiner

signed by

Director:

To the To To the F

Examine

by

Completed

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Certification:

edical

(Check only one)

29b. Signature and title of sertified

31. Dete filed (Month, Day, Year)

30. Name and address of

Maryland 21215-0020

Baltimore,

Directo

by

Completed

State Registrar

DHMH 16 Rev 6/95

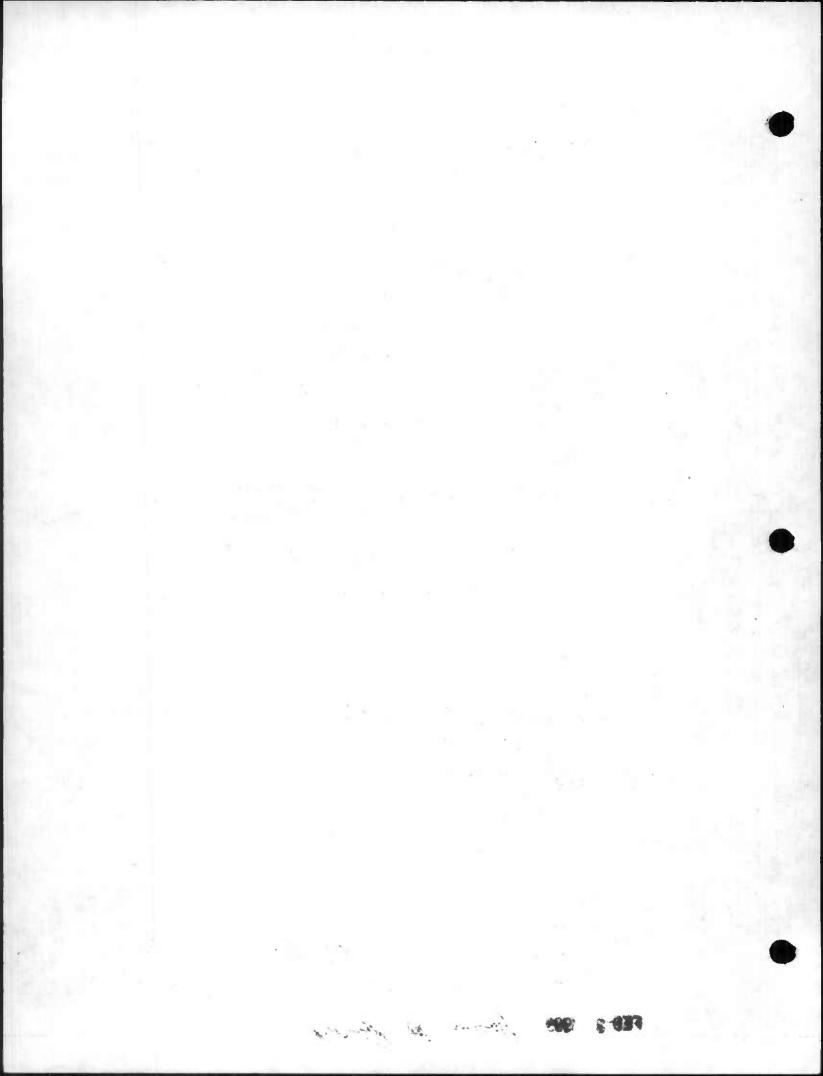


who completed gause of death (Item 23g)-(Type, Print)

3/9

62. Registrar's Signature

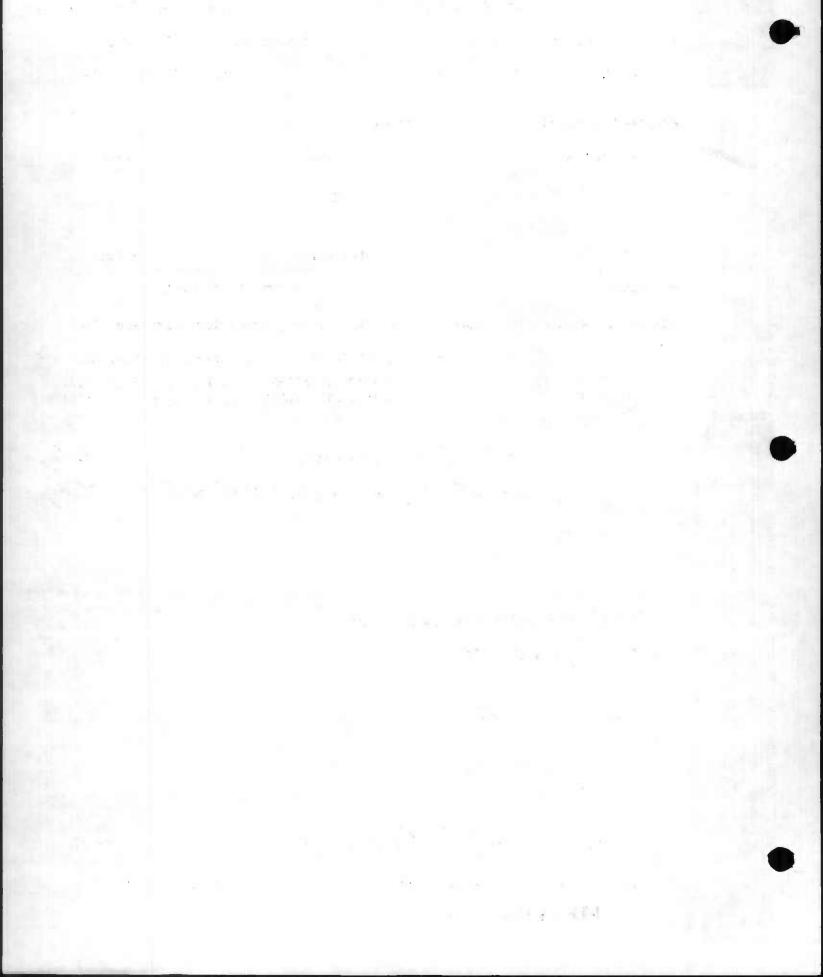
29c. License number



State of Maryland / Department of Health and Mental Hygiene

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		5. Social Security Number	6. Sex		. last birthday)	If Under 1 Yes	1						reion		
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	d 2 should be filed within 72 hours efter death with the Menyland II he and Mentel Hygiene. 7 Is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at To Be Committed by Funeral Director.	Maryland Frederick Frederick 10e. State 10b. County 10c. City, Town or Location Frederick Frederick 10f. Zip Coda										1 □XYes 2 □ No			
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Ball	permit. Page Depertment of Important: If any Injury or	21. Signature of Faregraphy Street	en Liculation	lect					SON FUN						
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<u>a</u>	iffical or, p	25. Was case referred to med	ical				26 Place	of Deat	h (Check only on						
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	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Combi	29a. Certifier 1 Certification	ying Physician: To t at Examiner: On the	basis of examin											
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** 1999 10:30 PM Leon Vermon Reinsberry Feb. 4, /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Frederick Memorial Hospital Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthpiece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Deys 1 X M 2 □ F 217-42-7754 55 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show 7 is marked other than "natural", or items 23s or 28s-f sho traumatic event, the Medical Examiner must be notified at M. Frederick Director 1 ☐ Yes 2 X No Middletown 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7134 Holter Rd. 21769 U.S.A. Funerai deeth 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2XNo If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Maritel Stetus permit. Pages 1 end 2 should be filed within 72 hours effer to Department of Health end Mentei Hygiena. Insportant: If item 27 is marked other than "natural", or fren any injury or other traumatic event. 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) farm owner 12 famer 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be John Verman Remsberg Lillian Schroyer 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Josephine H. Remsberg (Wife) 7134 Holter Rd., Middletown, Md. 20b. Place of Disposition (Neme of cemetery, cremetory or other place)
Reformed Cemetery 20e. Method of Disposition 20c. Location - City or Town, Stete 1 XBuriel 12 Cremetion 3 Removel from Stete 2/8 Middletown, Md. 5 Other (Specify) 21. Signature of Funerei Se 22. Name and Address of Fecility
Donald B. Thompson Funeral Home 31 E. Main St., Middletown, Md. indications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, and cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel Mmedic diseese or condition resulting in death) Examiner Examiner attanding physician end for usa as the buriel-trensit certificate be executed Sequentially list conditions, it eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in deeth) Lest P.O. Box 68760, Physician/Medical Due to (or as signed by the al Part II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Records, þ ata has been sig page 2 should b Completed 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy performed? completion of cause of deeth? certificata has 2000 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) 1 Yes 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 1 Inpatient 2 ER/Outpetient 3 DOA After this funeral 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Certification: Attending 2 Accident 5 Pending Investigation death. 1 ☐ Yes 2 ☐ No or Attend efter death Director: filled in by the 3 Suicide 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Pieca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ HomicIde To the Hospital or within 24 hours eff To the Funeral Di edicai 29a. Certifier Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end pleca, end due to the cause(s) end menner stated. completaly 29b. Signeture and title ot of niti 29d. Date signed (Month, Dey, Year) 29c. License number (item 23e) (Type, Print) A TOHNSON ORIVE, FREDBRICK, MI 31. Dete filed (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar

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17.	Fether's Neme (First, Middle, Last) EOWIN A. a. Informent's Neme/Reletionship (CHERYL B. Ro Method of Disposition 1 Burial 2 (Cremetion 3 C	ROTZ Type, Print)	19b	_	18. Mother's Nem	e (First, Middle, M											
19a	EOWIN A. a. Informent's Neme/Reletionship (CHERYL B. Ro b. Method of Disposition 1 Burial 2 A Cremetion 3 C	ROTZ Type, Print)			18. Mother's Nem	e (First, Middle, M											
20a	a. Informent's Neme/Reletionship (CHERYL B. Ro Method of Disposition 1 Burial 2 Arcremetion 3 C	Type, Print)					alden Sumem	10)									
20a	CHERYL B. Ro Method of Disposition Disposition CHERYL B. Ro Method of Disposition				GRETI	NA M.	MYE	RS									
	. Method of Disposition 1 Burial 2 Cremetion 3	iz, wir		. Mailing Address (Stre			•										
	1 ☐ Burial 2 ☐ Cremetion 3 ☐		20b. Piece of	Disposition (Neme of				City or Town, Stete									
21			CAPR	y, cremetory or other p	ATION, NC.			TEAD, MD.									
- 1.	Signeture of Funeral Service Licer		Ollyn														
21. Signeture of Funeral Service Licensee 22. Name and Address of Facility PETERS FUNERAL HOME, INC. 321 CARLISLE ST., GETTYSBURG, PA																	
23	23e. Pert1. Enter the disease, or compligations that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.																
	Shock, of heart failure. List only					intervel Between Onset end Death											
dis	mediate Ceuse (Finel eese or condition outing in deeth)	· PULSELES	ss ventr	ICULAR TAL	HYCARDIA	,		5MN									
Due to (or es e consequence of): MFTA ROLL(ACLDDS/C																	
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): ACLITE AORTIC OCCLUSIVE DISEASE Due to (or es e consequence of):																	
											d. PERIPHE	RAL ,	ARTERY	DISEASE	YEARS		
									Per	t II. Other algorificant conditions o	contributing to death h	out not resulting la	the underlying cause	given In Pert i	23h. Did tol	bacco use co	ntribute to the cause of death
								3 Probably 4 Unknow									
-	HOVERY PRICKY	DISCHSE,	WUN - JNS	NUN DEPEN	1-10,01												
1	PLABETES, CHRON	VIC OBSTA	PUCTIVE	PULMONARY	DISEASE	24a. Wes en perform	n eutopsy ned?	24b. Were autopsy findings eveilable prior to completion of ceuse of deeth?									
E	ND STAGE RENAL	DISEASE O	ON HEMI	DIALYSIS		1□ Ye	s 28 No	1 Yes 2 No									
_	Wes case referred to medical examiner?				Whore	th (Check only one											
27	1 ☐ Yes 2 No Manner of Death		ient 2 ER/Ou	tpetient 3LI DUA		ome 5 Resider	-										
	1 2 Neturel 5 Pending 2 Accident investigation		28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury et Work? M 1 1 Yes 2 No														
	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of In	28e. Place of Injury - At home, farm, streef, factory, office building, etc. (Specify) 28f. Location (Street end Number or Run City or Town, State)														
290			of exeminetion en	o, deeth occurred at the d/or investigation, in m				enner as stated. end due to the cause(s)									
29a	. Signature end title of certifier	end menner st	tated.	29c. Lice	ense number	29	d. Dete signe	d (Month, Dey, Year)									
	Ino Man!	TCHOU, ~	1.D.	RF	5-000	FE	BRUAR	4,12,1999									
30.	Name end eddress of person who	completed cause of	deeth (Item 23e)	(Type, Print)													

DHMH 16 Rev 6/95

· Registrar

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A- Www 111 Penn Street, Baltimore, Maryland 21201

10 21

30. Name and address of person who completed ceuse of death (item 23a) (Type, Print)

32. Registrar's Signature

State Registrar HARYS NOTO

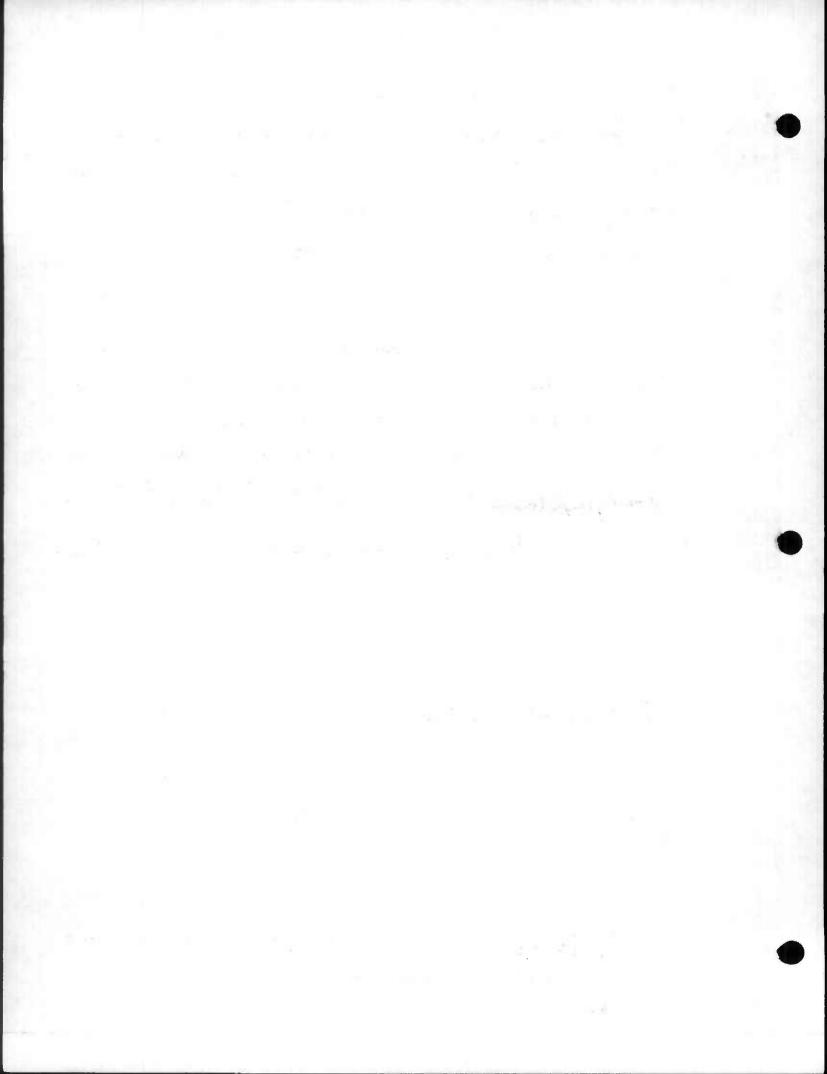
31. Date filed (Month, Dey, Xee)

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth **Physician** February by, 1999 Luella STICKLEY Mildred 12:58 AM /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Vindobona Nursing Home Braddock Heights Frederick If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Yeer) Jun 5,1896 Birthplace (State or Foreign Country) **Funeral** 1□M 2X F Months Days Hours 102 578-40-8689 Yrs. Director Maryland Usual Residence of Decedent with the Marylend 10e. Stete 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28a-f show traumatic event, the Medical Examinar must be notified at 10d. inside City Limits Maryland Maryland Frederick Braddock Heights Director 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6012 Jefferson Blvd 21714 U.S.A. Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Rece - American Indian, Bleck, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Peges 1 and 2 should be filed within 72 hours eftar I Depertment of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Iter any Injury or other traumatic event, the Medical Examina-1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify White þ 3€ Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementery/Secondary (0-12) Coilege (1-4or 5+) Homemaker Own Home 11 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be KARN Charles Bernard Lulu Virginia TITUS ပ 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) Mrs. Virginia Bailey/Daughter 7520 Ridge Road, Frederick, Maryland 21702 20b. Placa of Disposition (Nema of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 XBurial 2 Cremation 3 Removal from State Park Heights Cemty Feb 12, 1999 4 ☐ Donetion 5 ☐ Other (Specify) Brunswick, Maryland 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Keeney and Basford P.A. Funeral Home 23a. Perfl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, MD shock, or heart failura. List only one cause on each line. 21701 Approximate Intervel Between Onset end Deeth Physician ASPIRMON INEUMONIA /Medical Immediate Cause (Finel DAY disease or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner the bunel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Causa (Disaasa or Injury thet initiated events resulting in death) Lest Bud Due to (or as e consequenca ot) certificete be axec Box 68760. ettending physician Physician/Medicai Due to (or es a consequence of): as use a P.O. Part II. Other significant conditions contributing to deeth but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? the signed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 3 HEIMER'S MISENTE Records, þ 2 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes en eutopsy Completed peen paga 2 certificate 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vital 25. Was casa referred to medical exeminer? Be 26. Piace of Deeth (Check only one) 1□ Yes 2x No Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Hospital: 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this To the Hospital or Amanana, within 24 hours after death.

To the Funeral Director: After this managed in by the funeral 28c. Injury at Work? 27. Menner of Daath Certification: 28d. Describe how injury occurred 1 Netural 2 Accident 5 Pending Investigation 1 Yes 2 No 6 Could not be 3 ☐ Suicide 28e. Placa of injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicida 29a. Certifier 1 Certifying Physicien: To tha best of my knowledga, daeth occurred at tha time, date and placa, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the bests of axamination and/or investigation, in my opinion, deeth occurred at tha time, date and place, and dua to the cause(s) end mennar statad. Medical (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 16675 February 9, 1999 aum 30. Name end eddrass of person who completed cause of deeth (Item 23a) (Type, Print) 31. Date filed (Month, Day Sear 32. Registrar's Signature State

Registrar

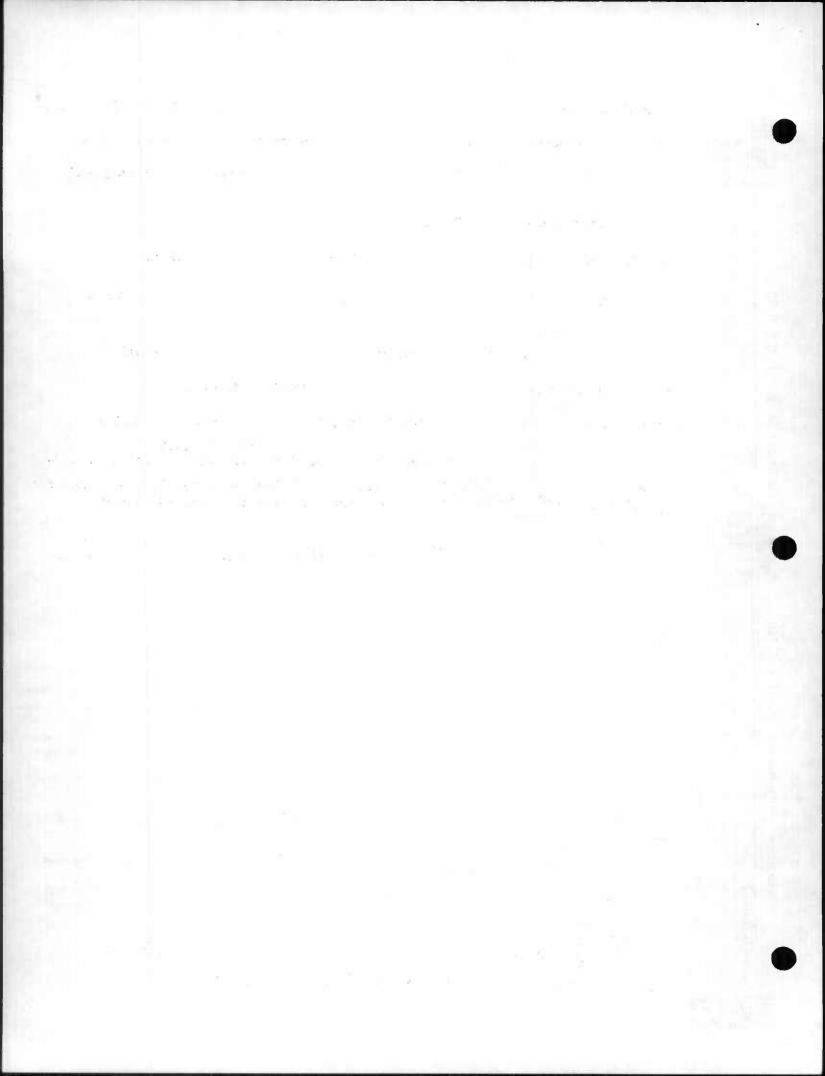


State of Maryland / Department of Health and Mental Hygiene

				C	ertificate o	of Death	-	eg. No.	0.5	93
Physic		Decedent's Name (First, Middle, Last Sai	muel L.	St.Cla	ir		2. Dete of Deel Month Februa:	Dey	Yeer	7:50 PM
/Medi Exami		4e. Fecility Name (If not institution, give	street end number)			4b. City, Town, or I		4c. County		1.70 11.
		Glade Valley Nur	sing Center	c		Walkers	ville	Fr	ederic	K
Funeral Director		5. Sociel Security Number 5. Sociel Security Number 6. Se 15 Usuel Residence of Decedent	x 7.Age (In yrs. lest birthde 82 Yrs	Months Dev		8. Date of Birth (Month, Dey, Feb. 23	Year) 1916	9. Birthplece Country) Virgi	(State or Foreign Inia
inyland show		10a. Stete 10b. County	1	0c. City, Town or	Location					Inside City Limits
Se Ma	cto	Maryland Frederic	k 1	Monrovia						1 ☐ Yes 2 🔼 No
# 9 P	Director	10e. Street end Number			10f. Zip Code		1	Whet Country?		
ath v	rai	12608 Fingerboard				1770			States	
ges 1 and 2 should be filed within 72 hours effer death with the Maryland it of Health and Mental Hygiene. It of Health and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Examinat must be incitined at	by Funeral	11. Meritel Status 1 Never Merried 2 Married 3 Widowed 4 Divorcad	12. Wes Decedent Even Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	er in U,S.		y Cuben, Mexican, Puèrto Rican, etc.)			4. Rece - American Indien, Bleck, White, etc. Specify: White	
72 ho	ted	15. Decedent's Edu	ication	16e. De	cedent's Usuel Occ	cupetion	dvina	16b. Kind of B	usiness/Industr	у
filed within 72 hours ef Hygiene. ther than "natural", or brt, the Med cal Exam	Completed	(Specify only highest grade Etementery/Secondery (0-12)	College (1-4or 5+)		16e. Decedent's Usuel Occupetion (Give kind of work done during most of wo life. DO NOT use retired) Owner Operator			Restaurar Companies		
d 2 should be file th end Mental Hy 7 Is marked othe traumatic event,	Be C	17. Fether's Neme (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, I	Aeiden Sumen	ne)	
should be nd Mental marked or umatic eve	To	Samuel Lewis St. C	Clair			Joanna (Cecil			
2 sho end is me		19a. Informent's Neme/Retetionship (7)	(pe, Print)	19b. M	elling Address (Stre	eet end Number or Ru	irei Route Number	City or Town,	Stete, Zip Coo	ie)
1 end 2 Health em 27 l		Thomas K. St. Clai				own Road,				
Pages 1 nent of H nt: If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F		20b. Pleca of Dis cemetery, o	sposition (Neme of cremetory or other p	olece)	Dete	20c. Location -	City or Town,	State
men tant: jury		4 ☐ Donetion 5 ☐ Other (Specify)		Resthave	n Memori	al Gardens	2/12	Frede	rick, M	aryland
permit. Page: Depertment of Important: If i eny injury or once.		21. Signeture of Funerat Service Licens	10 leswor	th !	22. Name end Add	dress of Fecility lolesworth ge Road, I	P. A. Fu	neral	Home	0872
Physician		23a. Pert1. Enter the disease, or complishock, or heart feilure. List only o	ications that caused the cause on each line.	e death. Do not	enter the mode of o	dylng, such es cardled	or respiretory error	est,	App	proximate ervel Between set end Deeth
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) e Hyper Natvenia								seek
nsit	Examiner		b	Dehyd	wation				u	reetc
ificete be executed g physician end as the bunal-transit	Exa	Sequentiatly list conditions, if eny, leeding to immediate	Du	e to (or es e cons	sequenca of):	1				
sicial buni									y	euvs
g phy as the	edicai	resulting in death) Lest				•			1/	0. 6
	7		d	Jerner	ntia				44	eavs
death e atte d for	icia	Pert tt. Other eignificant conditione cor	atributing to death but r	not resulting in the	underlylne ceuse	civen in Pert I	23h Did to	hacco use co	ntribute to the	cause of death
res that the designed by the a	by Physician/N	Total digilillocity conditions con	insuming to death but i	ot resulting in the	s driderlying cease	given in Perci.		s 2 No	\ .	y 4 Unknow
been should	Completed b						24e. Wes e	n eutopsy ned?	eveiteb	autopsy findings ate prior to ation of cause h?
	Com						1 □ Ye	s 2 No		s 2 No
ysician: The s certificate director, pag	Be	25. Wes case referred to medicat exeminer?					ath (Check only on	e)		
Physician: this certific	2	1 ☐ Yes 2 No	lospitel: 1 Inpatient	2 ER/Outpe	ment 3LI DOA		ome 5 Reside			
ing	sation:	27. Menner of Deeth Naturel 5 Pending Accident investigation	28e. Dete of injury (Month, Day Y	(eer) 28b. Time	y V	njury et Vork? Yes 2 No	28d. Describe ho	w Injury occur	red	
tal or Attendirs after death. I Director: A led in by the for	Certification:	3 Suicide 6 Could not be determined	28e. Pteca of tnjury buitding, etc. (- At home, farm, Specify)	street, factory, office	ca	28f. Location (St City or Town		er or Rural Ro	ute Number,
To the Hospital or / within 24 hours after To the Funeral Direction completely filled in b	edicai	29a. Certifier (Check only one) Certifying Physical Exami	sician: To the best of n ner: On the basis of ex end menner stete	aminetion end/or	eth occurred et the Investigetion, in m	time, date end plece y oplnion, deeth occu	, end due to the ca rred et the time, de	tuse(s) end me ate end pleca,	enner es steted snd due to the	l. cause(s)
To the within 2 To the comple	X	29b. Signeture and title of contrer			29c. Lice	ense nu <i>m</i> ber	- 2	9d. Date stgne	d (Month, Dey,	Year)
		30 Name and address otherson who or	10117	h /ltem 22a) /T	Do Brint)	14755	6	ebruar	y 8, 19	799
	1	30. Name end address of person who co	impleted cause of deel	n (Item 23e) (Typ	e, Print)					
		William H.	Johnson M	D 7:	1801 Fina	erboard R	and M		MA OTE	770

State of Maryland / Department of Health and Mental Hygiene Q Q Q D I Q I

			Cei	rtificate of	Death		Reg. No.	00194		
Physician	Decedent's Name (First, Middle, L.			2. Date of De Month	Dey	Year 3. Time of Death				
/Medical	Joan M. Swigert			Jan.		999 10:40 AM				
Examiner	4a Facility Neme (If not Institution, gi					r Location of Deat				
	Corsica Hills-Ge				Centrev			Anne's		
Funeral Director		Sex 1 □ M 2 \ F 6	In yrs. lest birthday) O Yrs.	If Under 1 Year Months Deys		n. (Month, De	th by, Year) 5, 1938	9. Birthplace (State or Foreign Country) Maryland		
death with the Meryland ms 23a or 28s-f show r must be not lined at	10e. State 10b. County	1	Oc. City, Town or Lo	cation				10d. Inside City Limits		
vith the Merylar or 28a-f show be notified at Director	MD Queen A	nne's	Chester					1 Yes 2 No		
or 28	10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?			
th wit	P.O. Box 352			21619	9		U.S.A.			
Fu Fu	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 🖾 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			Hispenic Origin? (ben, Mexican, Pue	(Specify Yes or No orto Rican, etc.)	Bled	e - American Indien, ck, White, etc. v: White		
natur oreal	15. Decedent's E (Specify only highest gr	ducation ede completed)	16a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most of w	orking	16b. Kind of B	usiness/Industry		
al Hygiene. I other than " went, the Max Be Comple	Elementery/Secondery (0-12)	College (1-4or 5+)		hier	9a)		Retail			
tal Hyg other went,	17. Fether's Name (First, Middle, Las)	18. Mother's No				Name (First, Middle, Maiden Sumame)			
Mental arked o attic eve	John Wright Malp	ass		Mildred McGuire						
end Menta is marked aumatic e	19a. Informent's Name/Relationship		19b. Maili	ng Address (Stree	t end Number or i	Ru <i>ral Rou</i> te Numb	er, City or Town,	Stete, Zip Code)		
27 Is r trau	Charles G. Lansin	nger III - S	on 105 t	Jtkewicz	Road, Ce	entrevill	le, MD	21617		
if of Health end Mental Hyg If item 27 is merked other or other traumatic event, To Be C	20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removel from State	20b. Place of Dispo cemetery, crer	sition (Name of netory or other pla	aca)	Jan. 28,	20c. Location	City or Town, State		
ment: lury	4 ☐ Donation 5 ☐ Other (Special	fy)	Woodlawn					ltimore, MD		
Department of Health Important: If item 27 is any injury or other tra	21. Signature of Funeral Service Lice	1. Helf	F			in & New		eral Home, P.A.		
Physician /Medical Examiner	23a. Part1. Enter the disease, or conshock, or heart feilure. List only Immediate Cause (Final disease or condition resulting in death)	θ	OM-Sw	roll ce			=	Approximete Interval Between Onset and Death		
ophysician end es the buriel-transit	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of): Due to (or as e consequence of): Due to (or as e consequence of): 1. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of the conditions contributed to the cause of th									
e ettending pod for use es										
y the eth sched fo hysici	Part II. Other significant conditions	contributing to death but r	not resulting in the u	nderlying cause g	iven in Part I.	23b. Dld	tobacco uas co	entributa to the causa of death?		
ed by the ettendin deteched for use / Physician/N						10	tes 2□ No	3 Probably 4 Unknown		
sete hes been signed by page 2 should be dete Completed by Pt						24a. Was	s an autopsy omed?	24b. Were eutopsy findings available prior to completion of cause of death?		
certificate has irector, page 2 be Comp						10	Yes 2 24No	1 ☐ Yes 2 ☐ No		
edificete hactor, page	25. Wes case referred to medical				26. Plece of D	eeth (Check only				
this certific ral director, TO Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	2 ER/Outpatier	nt 3 DOA	Since -			ner (Specify)		
within 24 hours effer deeth. To the Funeral Director: Affer this certificate hes completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Dey Y	28b. Time o	28c. Inju	40 Hursing Home 5 Hesidence 6 Dother (Specify)					
within 24 hours effer deeth. To the Funeral Director. Affert completely filled in by the funer. Medical Certification:	3 Suicide 6 Could not 4 Homicide determined	200. Place of injuly	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					ber or Rural Route Number,		
in 24 hour he Funer pletely fill edical		nysician: To the best of n miner: On the basis of ex and manner state	amination and/or in							
within 24 hours of within 24 hours off To the Funeral Dir completely filled in Medical Ceri	29b. Signature and little of certifier	wite mainer states		29c. Licen	se number		29d. Date signe	ed (Month, Day, Year)		
8 ≒€	· SUL	LV-					1/21	100		
	30. Name and address of person who	completed cause of deat	h (Item 23a) (Type,	Print) Dru	2565E	, L. Ma	1216	15		
State	31. Dete filed (Month, Day, Yam)	32. Registrar's	Signature							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death February 7, 1999 **Physician** Florence Agnes Scovitch 4:25 am /Medical 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Laurel Prince George | Months | Days | Hours | Min. | March | 29,1906 5. Social Security Number 6. Sax Birthplace (State or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** 1 M 2 TF Months 220 90 0994 92 Maryland Director Usual Rasidance of Decedent the Manylend 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 le marked other than "natural", or itema 23a or 28a-f ehow other treumatic event, the Medical Examiner must be notified at 1X Yas 2 No Director Prince George Maryland Laurel 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 711 Park Avenue 20707 IISA death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11 Marital Status Was Decedant Evar in U,S. Armed Forcas? 72 hours efter 1 Yas 2 No 1 Nevar Married 2 Married Specify: White 3altimore, Maryland 21215-0020 1 ☐ Yes 2 K No Specify: à 3 d Widowed 4 □ Divorced Yaar or Datas: Completed 16a. Decedent's Usuaf Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed within 1 Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "n any injury or other treumatic event. The Exercise Elementery/Secondary (0-12) College (1-4or 5+) 6 Homemaker Own home 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be 0 James Robert Herberson Mary Catherine Peters 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Cyrena Veitch /sister 602 Park Avenue, Laurel, Maryland 20707 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Mathod of Disposition Dete 20c. Location - City or Town, Stata 1 ☐ Burial 2 【Cramation 3 ☐ Removal from Stala 4 ☐ Donalion 5 ☐ Othar (Specify) Metro Crematory 2/8/99 Catonsville, Maryland 21. Signature of Funeral Service Licensi 22. Nama and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, Maryland 20707–4389
Approximata
Interval Between
Onset and Death Part1. Enter the disease, or complications that ceused the death. Do not enshock, or heart failure. List only one ceuse on each line. **Physician** LOW GESTIVE HEART FAILURE /Medical Immediata Causa (Final VEAK disaasa or condition rasulting in death) Examine Due to (or as a consequence of): Examin attending physician and for use es tha burial-transit Sequentially list conditions, if any, leading to immadiata ceuse. Enter Undarfying Ceuse (Disease or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): P.O. Box 68760 Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by it VALVULAN HEART DISPASE 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by CHRONIC OBSTRUCTIVE LUNG DISEASE 24b. Wara autopsy findings evailable prior to 24a. Was an autopsy performed? Completed complation of cause of death? hes ANDWIA 1 Yas 2 No certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was cesa rafarred to medical axaminar?

1 Yes 2 No Be 26. Place of Deeth (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Dinpatiant 2 2 ER/Outpatient 3 DOA 28e. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 (BNatural 5 Pending 1 Yes 2 No invastigation 2 Accident 6 Could not be dataminad 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical completely 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifier 124997 30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

State Registrar A. CASAS

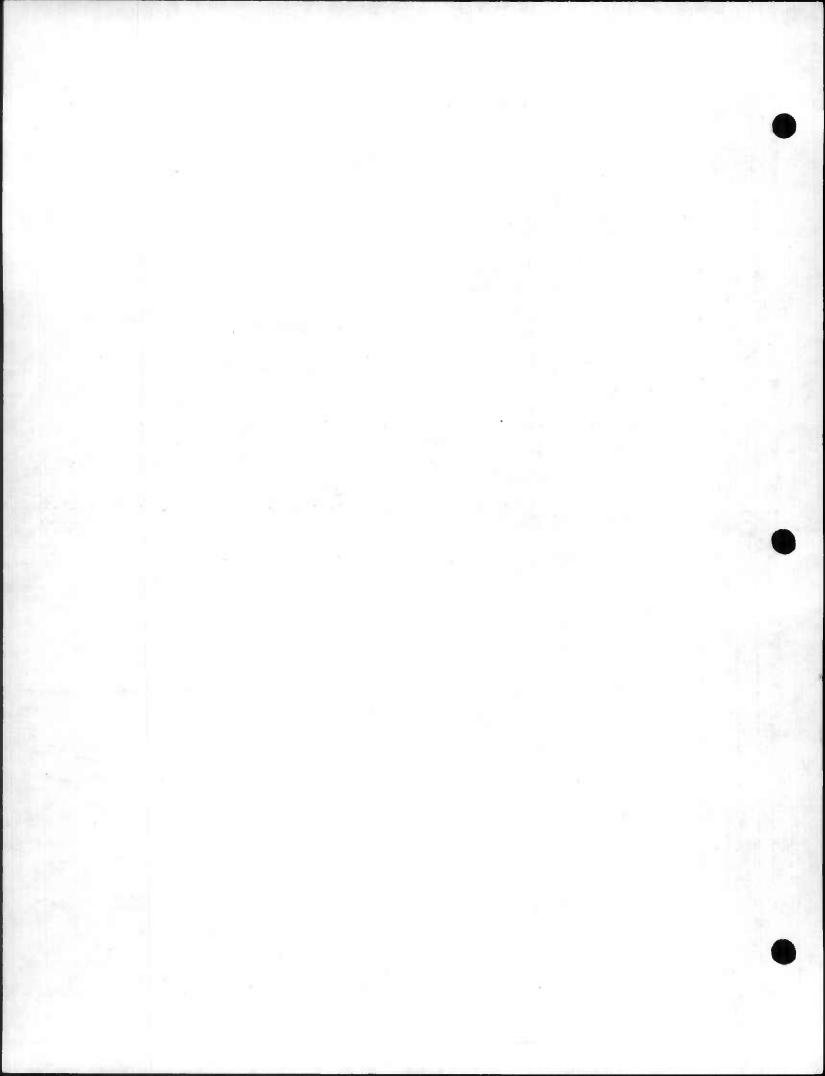
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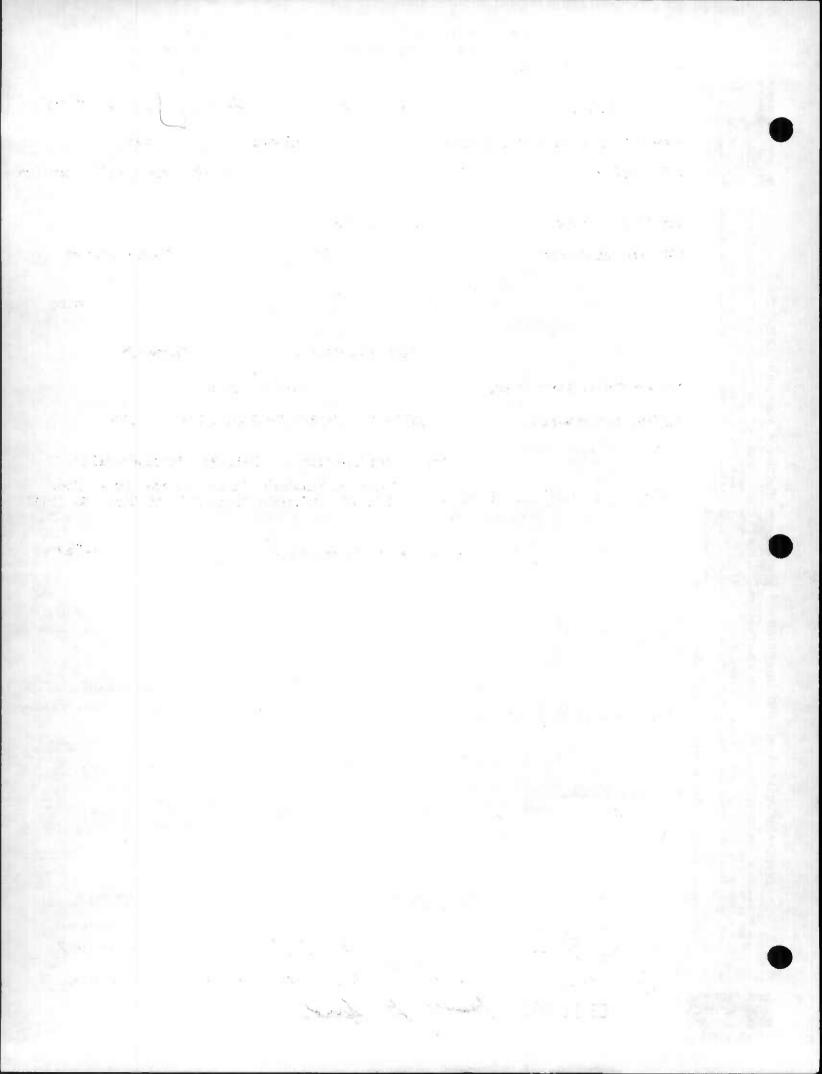
32. Registrar's Signatura

8317 CHERRY LANG LAURER

MD



	Item: 12 per F.H 1. Decedent's Name (First				00	,ou	te of	D G G G G G G G G G G	2. Date of Dea			3. Time of Death	
nysician			_		500	RROG	2		Month FZSN4A	Day 10, 19	Yaar 999	4:45 PM	
Medical xaminer	4a Facility Nama (If not institution, give street and number)							4b. City, Town, or L					
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neral	5. Social Security Number	6. Se	9x 7. Ag		last birthda	y) If Und	If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth				Birthplace (Stata or Foraig Country)		
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Directo	Maryland 10e. Street and Number	Howard			EIII	cott (ip Code			10g. Citizen of \	What Coun	ntry?	
4 0	9921 Postwic	k Road					2104	12		United States			
iner must	11. Marital Status		12, Was Decedent	Decedent Evar In U.S. 13. Was Decedent				ecify Yas or No					
leted by Funeral Director	1 Never Married 2		Armed Forces? 1 Yes Sive Year or Datas:	195 198	0	13. Was Decedent of Hispanic Origin? (Specify Yas If Yas, specify Cuban, Mexicen, Puarto Ricen, e			Hicen, etc.)	Specify:		White	
	15. Do	ecedent's Ed	ucetion		16e. Dec				kina				
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traum	19a. Informant's Name/Re Jeffrey Spar									Number, City or Town, State, Zip Code) Imbia, MD 21044			
othert	20a. Method of Disposition		/11	20b. F	Place of Dis	position (N	ame of		Date	20c. Location		own, State	
0 0	1 Buriai 2 ☐ Cren		(cemetery, c	ematory or	other pla	1						
any injury or ance.	4 ☐ Donation 5 ☐ O 21. Signature of Funeral S			Cr	est L			ery 2	-13-99	Marriot	ttsvi	IIe, MD	
eny l	21. Signature of Furieral	C-01	1 = 1 2	0 0		Harry	H. V	Vitzke's					
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ician	shock, or heart feilur	e. List only	one cause on each li	ine. '							1	Interval Between Onset and Death	
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burial al E	Sequentially list condition if any, leading to immadia ceuse. Enter Underlying cause (Diseese or Injury that Initiated events	C											
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ache	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.									23b. Did tobacco use contribute to the cause of dea			
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P P	27. Manner of Death	Panding	28a. Date of Inju (Month, De	ury ay Year)	28b. Time Injur	1	28c. Inju Wo		28d. Describe	how Injury occur	rred		
uneral dir	2 ☐ Accident investigation					M		Yas 2 No	20f Lastine f	Ctrant and Al.	haras D	of Pouto Atm has	
the funeral dir		hanimatah							City or To	wn, State)	ver or Hun	si rioute (vum ber,	
in by the funeral dir		determined											
ely filled in by the funeral dir	3 ☐ Sulcida 6 ☐ 4 ☐ Homicide	determined ertifying Ph	ysician: To the best	of my kno	wiedge, de	ath occurre	d at the til	me, date and place	, and due to the	date end place	anner as s	tated.	
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Completely filled in by the funeral din Medical Certification: To	3 Suicida 6 4 Homicide 29a. Certifier 1 C (Check only one)	ertifying Physical Examination of the person who do	yaician: To the best inner: On the basis of and manner st	of examine tated.	ation and/or	investigetic	on, In my o	opinion, deeth occu	rred at the time,	date end plece,	end due to	Day Year)	



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day F & B JROTHY E. S1. 4:15 PN 4a Facility Name (If not institution, give street end number 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard 8. Date of Birth (Month, Dey, Year) Jan 22, 1915 If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sax 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 1 M 2 XF Months Days Yrs. Massachusettes 011 18 8575 84 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2X No Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13522 Orion Drive 21036 United States 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Bleck, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Charles Connors Laura Murphy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lorraine D. Kennedy/Daughter 13522 Orion Drive Dayton, Maryland 21036 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ignatius Catholic Cm. 2-12-99 Chapel Point, MD 22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 21. Signature of Funeral Service Licenses Dune a (A 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STROKS BRAIN Due to (or as a consequence of) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 → Yee 2 No 3 Probably 4 Unknown SEMA 24b. Were eutopsy findings available prior to completion of ceuse of death? 24e. Wes en autopsy performed?

Physician /Medical Examiner

The law requires that the deeth certificate be executed

Box 68760

P.O.

Division of Vital Records,

Ö

Injury

any is

Physician

/Medical

Examiner

10a State

Funeral

Director

28a-f show

Director

Funeral

þ

Completed

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours aftar death v Department of Haalth end Mental Hygiena. Important: If Item 27 Is marked other than "natural", or Items 23s

Baltimore, Maryland 21215-0020

with the Marylend

Examiner attending physician and for use es the bunal-transit Physiclan/Medical 80 the signed by þ Completed peeu certificate has Mospital or Attending Physician:
 24 hours efter death.
 Funeral Director: After this certifica Be

2

Certification:

Medical

funeral

filled in by

completely

within 2 \$

0

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

1 ☐ Yes 2 ☐ No

1 ☐ Yes 2 ☐ No

25. Was cese referred to medicel examiner? 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 Mpatient 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending Investigation 1 Matural 1 ☐ Yes 2 ☐ No

2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end manner as stated.

845

29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature apt title of ophili 29c. License number 29d. Date signed (Month, Dev. Year)

mo 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

JR SCHAE EDW ARD

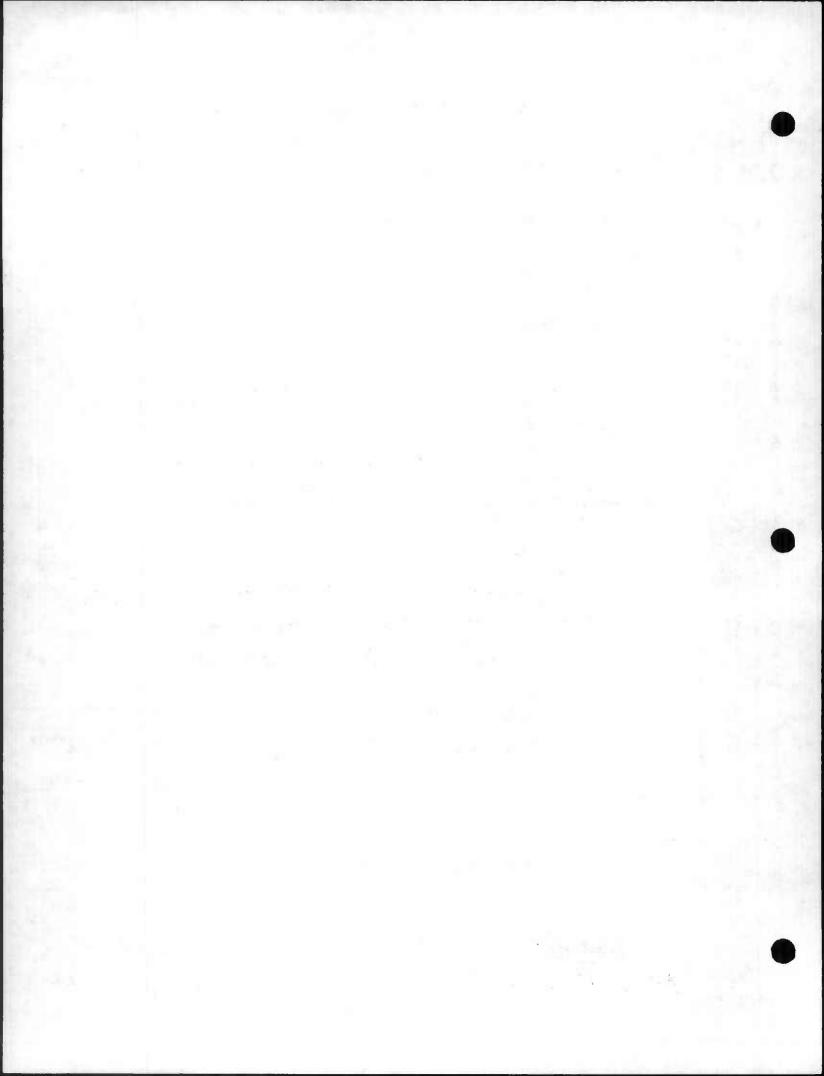
Howar) COUNTY

State Registrar FEB 1 32. Registar's Signature

- 14 P. W. W. C. C. C. V. 15.60 - 7.20 HOLLAND CHOICE THE STEEL STREET

State of Maryland / Department of Health and Mental Hygiene

			Certificate of	Death		Reg. No.	05198			
Physician	1. Decedent's Neme (First, Middle, Last)	0-0	1 = 0		2. Date of Dea Month		3. Time of Death			
/Medical	BERNARD	SEG			01	17	79 10-46 P.M			
Examiner	4a Facility Name (If not institution, give street and number)	1 -11.		4b. City, Town, or	Location of Death	PRIN				
	LAUREL REGIONA 5. Sociel Security Number 6. Sex 7. Age	(In yrs. last birt		the state of the s						
Funeral Director	5. Sociel Security Number 579–16–8219 Usuel Residence of Decedent 6. Sex 12M 2 F 7. Age	8,2.		Hours Min.		7-16	9. Birthplace (State or Foreign Country) Maryland			
ene. than "natural", or liams 23s or 28e-f show the Medical Exercises court be notified at sympleted by Funeral Director	10a. State 10b. County	10c. City, Towr	or Location				10d. Inside City Limits			
or 28a-f ahow on notified at Director	M.D Prince George	Beltsv				1 ☐ Yes 2 ☐ No				
or 28 a not	10e. Street and Number		10f. Zip Code			10g. Citizen of Wh	net Country?			
diam	6504 Muirkirk Road		20705			USA				
by Funeral Director	11. Merital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced 12. Wes Decedent E Armed Forces? 1 X Yes 2 N 1 Yes 2 N Yes or Detes: 1	If Yes, specify Cut		lispante Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Rece Bleck Specify:	- American Indien, , White, etc. hite			
event, the Madical I	15. Decedent's Education		Decedent's Usual Occup	pation		16b. Kind of Bus				
Die Se	(Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5-	.)	(Give kind of work done life. DO NOT use retire	d) auring most of wo	Post		States			
Comp	Grade 10	Cl	erk				fice			
D S	17. Father's Neme (First, Middle, Last)				me (First, Middle,	Maiden Sumame				
To He	George Lewis Seger			Lida Ta	•					
other traumatic event, the	19e. Informent's Neme/Reletionship (Type, Print)		Meiling Address (Street							
ther	Ruth R. Seger /spouse 20a. Method of Disposition		04 Muirkirk Disposition (Name of	Road, B	Dete		and 20705 ity or Town, State			
000	1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State	cemeter	y, crematory or other pla	1						
uler)	4 Donetion 5 Other (Specify) 21. Signeture of Funeral/Service Licensee	Maryla	nd Veterans 22. Name and Addre		1/25/99	Cheltenh	am, Maryland			
Important: If item 27 is marked other any injury or other traumatic event, it once. To Be Co	I Low If you like		Donaldson	Funeral			20707–4389			
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5 CI D	CITICOLVIC ORDITION	0 -111					completion of cause of death?			
rector, pege			~	DISEASI	101	es 200No	1 ☐ Yes 20X No			
director.	25. Wes case reterred to medical examiner?			26. Place of De	eth (Check only o	ne)				
5	1 ☐ Yes 2 No Hospitel: 1 ☐ Inpatien	2 ER/Out	patient 30 DOA Oth	ner: 4 Nursing h	tome 5 ☐ Resid	ence 6 Other	(Specify)			
- LO	27. Menner of Deeth 1 Neturel 5 Pending 28e. Dete of Injury (Month, Day		jury Wor		28d. Describe h	ow injury occurre	d			
the cat	2 Accident Investigation			Yes 2 □ No						
in by	4 Homicide determined 28e. Plece of Injur	y - At home, fer (Specify)	m, street, factory, office		28f. Location (S City or Tow		r or Rural Route Number,			
To the Funeral Director: After to completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one) Medical Examiner: On the basis of end manner state	xaminetion and	deeth occurred et the tir Vor investigation, in my o	ne, date end plece pinion, death occu	e, end due to the our arred et the time, o	ause(s) end men dete end plece, ar	ner es stated. nd due to the cause(s)			
To the Funeral Director: A completely filled in by the fundamental Medical Certificati	29b. Signature end title of certifier	ou.	29c, Licens	e number		29d. Date signed	(Month, Day, Year)			
¥ 8	Aldul Vayelin	MIX		- 1		01/1	2199			
+1	through the	110		21294		07/10	111.			
	30. Name and address of person who completed cause of dea	2007	FART MA	ANE RE	AN /AI	REIM	· D. 20724			
State	31. Date filed (Month, Day, Year) 32. Registrar	's Signeture	1011111	TIVE NO	יוש בחט	WEL, 11	D. 25727			
State Registrar	31. Date filed (Month, Day, Year) JAN 2 1 1999 32. Register	neve	D. Ann	Val.						



State Registrar

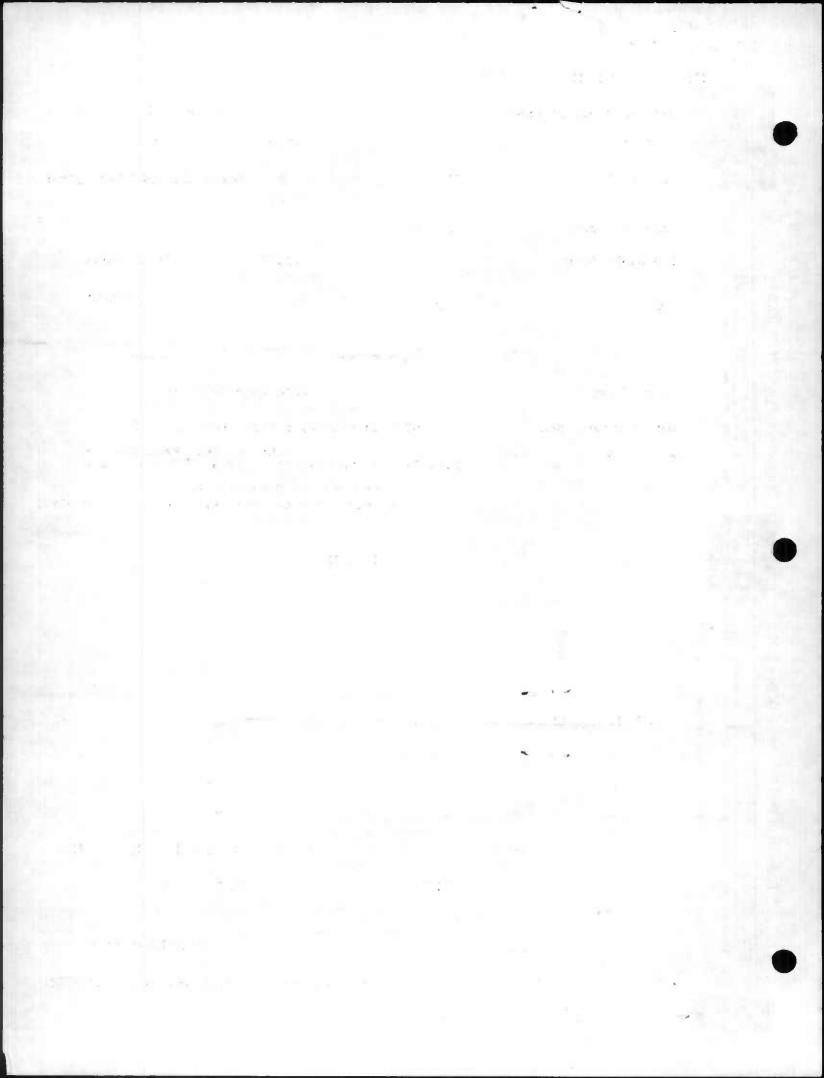
V. Chute MD

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32. Registrer's Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No: 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month JAN Year Cy Cy 9:46 Pm WANDA VALLEE 4c. County of Death 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death REGIONA 7. Aga (In yrs. last birthday) If Under 1 Year Princo 6-L LAUREL LAURE! MO if Under 24 Hrs. 8. Date of Birth Hours | Min. (Month, Day, Year) 9. Birthplaca (Stata of Foraign Country) 5. Social Security Number 1□ M 2X F Months Days 553-32-8949 98 Aug 22, 1900 Illinois Usual Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yes 2 No MD Anne Arundel Laurel 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 444 Henryton South 20724 USA 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas ≥ 2M No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Ongin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, 11. Marital Status Black, Whita, atc. 1 Nevar Married 2 Married Specify: White 1 ☐ Yas 2 ☑ No Specify: 3 Widowed 4 □ Divorced 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada complated) United States Collaga (1-4or 5+) Elementery/Secondary (0-12) Government 2 years Clerk 18. Mothar's Name (First, Middle, Maidan Sumama) 17. Father's Name (First, Middle, Last) George Fredrick Petersen Amelia Sophia Johnsen 19b. Mailing Addrass (Straat and Number or Rurel Routa Number, City or Town, Stefa, Zip Coda) 19a. Informant's Name/Ralationship (Typa, Print) Thomas Vallee /son 444 Henryton South, Laurel, Maryland 20724 20b. Place of Disposition (Nema of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 🗓 Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cem 3/3/99 Arlington, Virginia 22. Nama and Addrass of Facility Donaldson Funeral Home, P.A. 21. Signature of Funarai Sarvice Ligante 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Part1. Enter the divided of complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart full or List only one cause on each line. Approximata Interval Batween Onsat and Death Immediata Causa (Final disaasa or condition resulting in death) Sequantially list conditions, if any, laeding to immadiata cause. Entar Underlying Ceusa (Disease or injury that initiated avants rasulting in death) Lasf Dua to (or as a consequance of): Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part i. 23b. Did tobacco usa contributa to the cause of death? 3 □ Probably 4 Unknown 1 Tyes 2 No Heart 24b. Ware autopsy findings available prior to 24e. Wes an eutopsy performed? tes Mellitu completion of cause of deeth? Meningioma 2 X No 1 ☐ Yas 2 No 25. Was casa referred to madical axaminar? 26. Place of Death (Check only ona) Hospitel: 1 ☐ Inpatiant 2 ER/Outpetiant 3 ☐ DOA 1 ☐ Yas 20 No 27. Mennar of Death Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? Naturel 2 Accident 5 Panding investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicida 28f. Location (Straat and Number or Rurel Route Number, City or Town, Stata) 28e. Place of Injury - Af homa, farm, straaf, factory, office building, etc. (Specify)

The law requires that the death certificata be axecuted Records, P.O. Box 68760. Division of Vital

physician and the burial-transit attanding for use es signed by the a his certificata has b after death.

Director: After this certifica funeral rector: / A 24 hour. the Funeral Direction Hospital

Physician

/Medical

Examiner

Funeral

Director

"naturel", or items 23s or 28s-f show

permit. Pages 1 and 2 should be filed within 72 hours effer death with 1 Department of Health and Mentel Hygiena. Important: if item 27 is marked other than "naturel", or Nema 23a or 2 languing or other traumatic event, the Mexical Examinate must be repose.

Physician /Medical

Examiner

Examiner

Physician/Medical

Aq

Completed

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4 Homicide

29b. Signatura and title of certifier

31. Data filad (Month, Day, Year)

FEB 03

29a. Cartifian

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

the Maryland

Certification: To To the Hospi within 24 hou To the Funer completely fil edicai

> State Registrar

Cartifying Physician: To the best of my knowladge, daath occurred at tha tima, data and place, and dua to the cause(s) end menner as statad.

Medical Examiner: On the basis of axamination and/or investigation, in my opinion, daath occurred at the time, data and place, end due to the cause(s) end manner stated. 29c. Licensa number

29d. Data signad (Month, Day, Year)

22966

30. Nama and addrass of person who completed cause of daath (Itam 23a) (Type, Print)

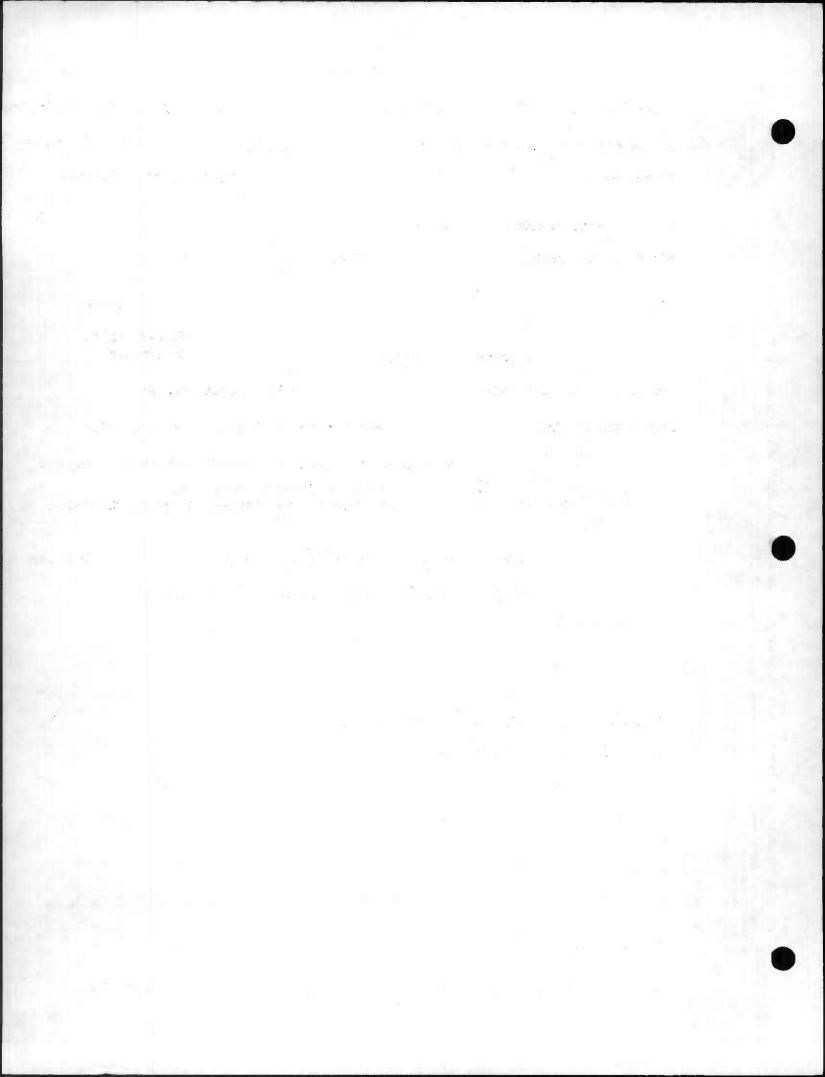
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Geneva

land Region Hospital.



	8	tate of Marylan		ificate of			giene Reg. No.	0.5	201	
1. Decedent'a Name (First, Middle, Last) Physician Nan Elizabeth Wettrick						2. Data of Dea Month	Day	Year	3. Tima of Death	
/Medical	Nan Elizabeth		February 4, 1999 0005			0005				
Examiner	4a Facility Nama (If not institution, give stre				4b. City, Town, or L					
Funeral	S Control Country Mumbers C Con. The Application of the Application of the Control of the Contro				lavre de (8. Date of Birth		9. Birthplace (Stata or Foraign Country)		
Director	215-54-1178 1DM	返 F 84	Yrs.	Months Days	Hours Min.	(Month, Da May 11,	7, Year)	Kent	ucky	
D s	Usuat Residence of Decedent 10a. Stata 10b. County	10c Cit	y, Town or Loca	ation				11	Od. Inside City Limits	
Aarylar Tahow										
vith the Marylar o or 28a-f show be notified at	10e. Street and Number	10f. Zip Code			10g. Citizen of V	/hat Count	try?			
th with the sale of the sale o	723 Webb Street		21001			U.S	Δ			
Officer death v ritems 23 other man	11. Marital Status 12.	Was Decedent Ever in U, Armed Forces?						- America	- American Indien, Whita, atc.	
Dy	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 🛣 No Specify:			, , , , , ,	Specify: White				
1 21215-0 led within 72 ho byglene. The the fraction of the completed Completed	15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Giva kind of work done during most of workin life. DO NOT use retired)			16b. Kind of Businass/Industry			
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aryiand 2 should be filed marked other umatic avant, To Be Cc	Oscar Owen Blankens	hip		Mary Susan Parrott						
To the second	19a. Informant'a Name/Relationship (Type,		19b. Maiting	b. Maiting Address (Street and Number or Rural						
	Charles Wettrick (S		723 We		et, Aberd			2100		
	20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Rem	oval from State	emetery, crema	itory or other plac	1	Data	20c. Location -	-		
Baitimo Permit. Peges Department of important: if it many injury or once.	4 Donation 5 Other (Specify) Spring Dale Cemetery 2/8/9 21. Signature of Fugeral Service Licensee 22. Name and Address of Facility									
Bait Permit. P	21. Signature of Fundral Service Licensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399									
30	23a. Fert1. Entar the disease, or complicate shock, or heart teiture. List only one complicate shock.	ons thet raused the deet						1	Approximeta Interval Between	
Physician /Medical Examiner	Immediate Cause (Finat diseasa or condition resulting in death) Due to (or as a consequence of):									
68760, ficate be executed physician and as the burial-transit edical Examiner	Sequentially list conditions	Due to (o	r as a consequ	ence of):				i		
.O. Box 68760, the death certificate be executed by the attending physician and solved for use as the burial-transit hysician/Medical Examil	if any, leading to immediata cause. Enter Underlying Cause (Disease or injury									
58760, licate be exprised and s the burial Eddical E	tresulting in death) Last Due to (or es e consequence of):									
	d									
Geath death death of for the store of forms of f	Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death?									
Ital Records, P.O. Box slen: The law requires that the death cert artificate has been signed by the attending actor, page 2 should be detached for use Be Completed by Physician/M	ONELIAM MAZA						19 Yes 2 No 3 Probably 4 Unknown			
Ords, P requires that requires that been signed be contained be detered by PP	William I was a series of the									
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Vital I Vital I I I I I I I I I I I I I I I I I I I	25. Was case referred to medical 26. Place of Deeth (Check only one)									
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On of On of On of On Of On Of On Of On Of On Of On Of On Of On Of On On On On On On On On On On On On On	27. Manner of Death Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be									
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Division Division or Attanding after death. Director: Afte d in by the fund ertification	28e. Place of Injury - At homa, farm, atreet, factory, office building, atc. (Specify)									
Division of Tothe Hospital or Attending Parties and death of the Funeral Director. After the completely filled in by the funeral Medical Certification:	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.									
the He Fundate Policies	(Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and menner stated.									
To the common	29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year)									
	30. Negwe and address of person who compl	many the state of								
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State	31. Date filed (Month, Day, Year)	32. Hegistrar's Signa	ture	1	0	-				
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31. Date filed (Month, Day, Year)

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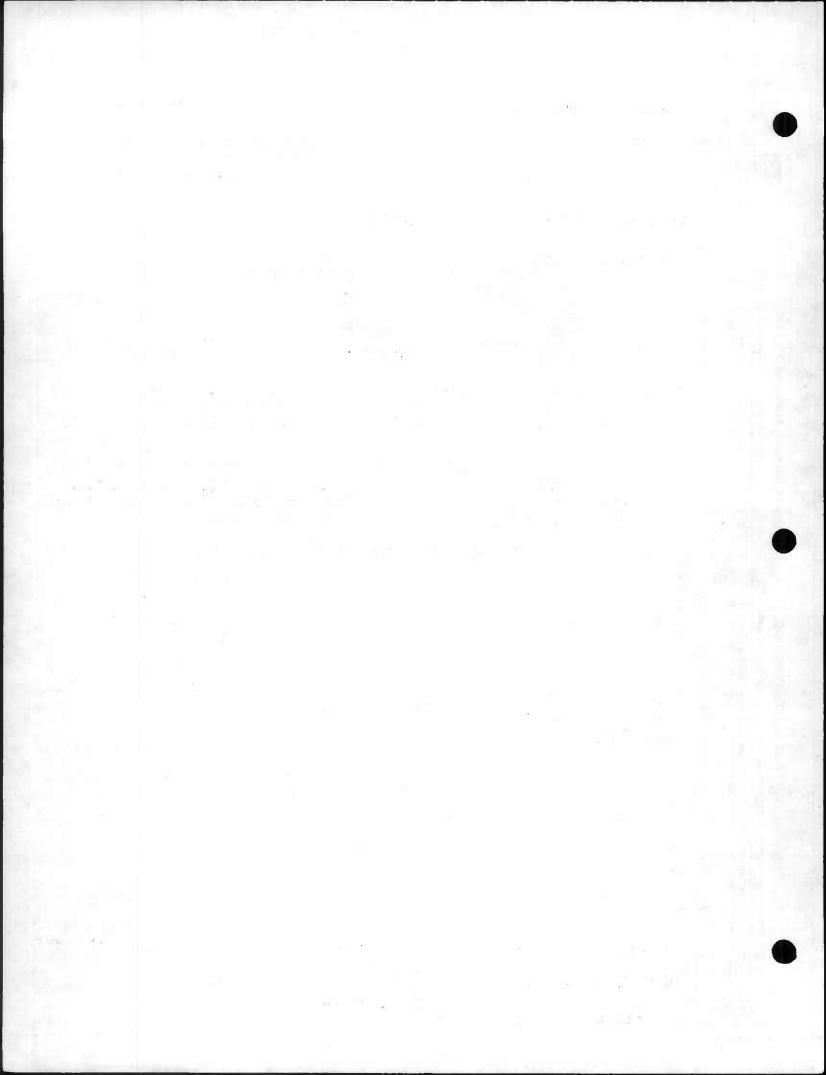
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of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Yee Paul Fred Wood, Sr. 12:30PM 1999 Feb. 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) Queen Anne's Centreville 2215 Church Hill Road If Under 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) 1[XX 2 F Months Deys 213-24-1349 Yrs. 70 Jan. 2,1929 Maryland Usuel Residence of Decedent 10e Stete 10b County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Md. Queen Anne's Centreville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2215 Church Hill Road 21617 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Merried & Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Self-employed 12 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Father's Neme (First, Middle, Last) Joseph Haston Wood Florence Jane Breeding 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Louise M. Wood (Wife) 109 Central Dr., Chestertown, Md. 21620 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, cremetory or other place) Feb. 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Chesterfield Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) Centreville, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Fellows, Helfenbein & Newnam Funeral Home 408 S. Liberty St., Centreville, Md. Enter III disease, or complications that caused the with. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete Intervel Between Onset end Death Immediate Cause (Finel diseese or condition resulting in deeth) Due to (or es e consequence of) Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or as a consequence of): Due to (or as a consequence of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 1992 24b. Were eutopsy findings eveilable prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 1 Yes 2 No 1 Yes 2€ No 25. Wes cese referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 图 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending Investigation 1 Netural 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide

physician and the burial-transit requires that the death certificate be executed P.O. Box 68760 the 60 USB ! this cartificata has funaral Aftar

Physician

/Medical Examiner

Examiner

Physician/Medical

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Certification:

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290. Signature and title of certified

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Funeral

Director

Itsm 27 is marked other than "natural", or items 23s or 28s4 show other traumetic event, the Medical Examiner must be notified at

with the Maryland

or Attending Physician: after death. Director: Aft Mospital of 24 hours a Funeral D To the To the To the

> State Registrar

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) M.D.; Ralph E. Libby, 31. Dete filed (Month, Day, Yeer)

204 Medical Center Rd., Grasonville, Md. 21638 32. Registrar's Signeture

WD

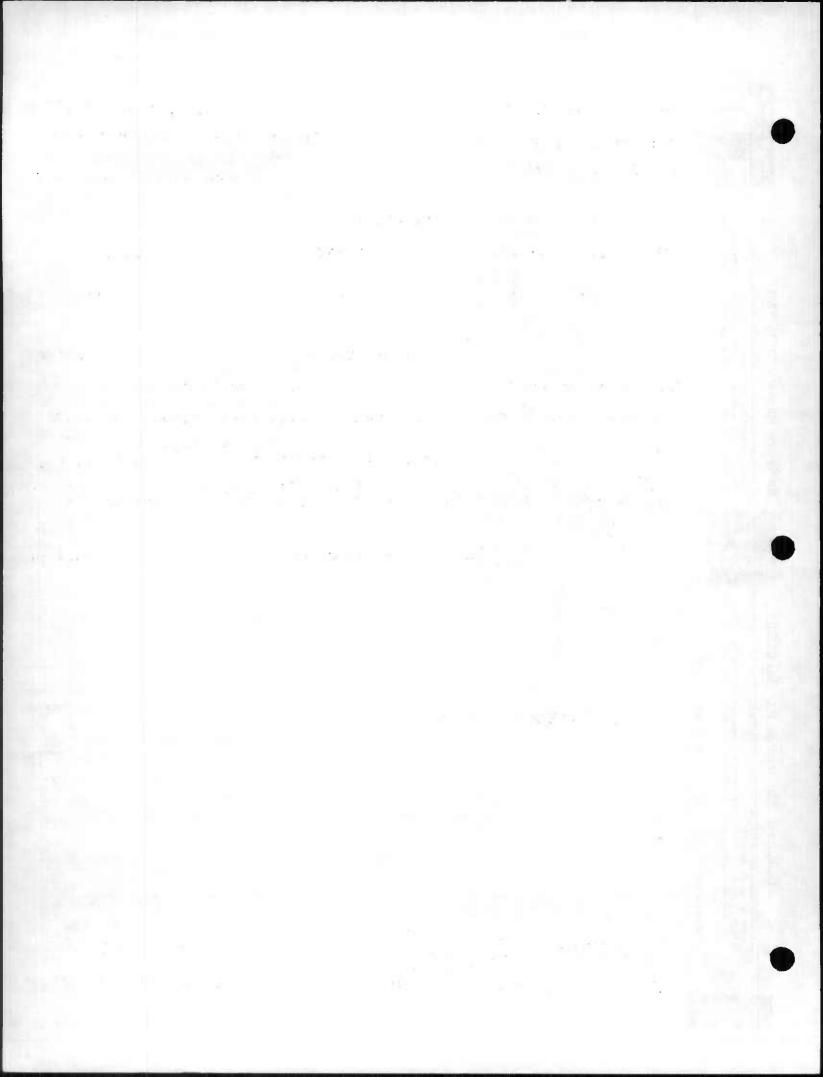
1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

2000575

29d. Date signed (Month, Day, Yeer)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Daath 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month ohn Joseph 1999 6.400m Feb 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Prince George Golden Oaks Nursing Home Laurel If Under 1 Year | If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year Mar 02, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Months 1 M M 2□ F Days Hours Min. Yrs. 1913 Maryland 85 705-14-0020 Usuel Residence of Deceden 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Prince George Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 704 Laurel Avenue 20707 USA Apt 2 Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, 12. Was Decedant Evar in U,S. Armed Forces? Bleck, Whita, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1 Nevar Married 2 Memied Specify: White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) Construction Grade 5 Laborer 18. Mothar's Neme (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) unknown unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 19e. Informent's Name/Raletionship (Type, Print) Mary Grace White /spouse 704 Laurel Ave. Apt. 2, Laurel, Maryland 20707 20b. Plece of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☐ Buriet 2 X Cremetion 3 ☐ Removel from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory, Inc. 2/6/99 Catonsville, Maryland 22. Name and Addrass of Facility Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 or complications that causad the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, and only one cause on each line. Approximate Intervei Between Onsat end Deeth Immediate Cause (Finat diseese or condition resulting in death) Sequentially list conditions, if any, leeding to immadiata causa. Entar Undarlying Causa (Disaesa or Injury Due to (or as e consequence of) thet initieted events resulting in death) Lest Due to (or es e consaquance of): Pert It. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert It. 23b. Did tobacco use contribute to the causa of death? 1 Yas 2 No 3 Probably Whitenown ailure na 24b. Wera eutopsy findings eveilable prior to completion of cause of death? 24e. Wes en eutopsy 1 Yes 2 No 1 □ Yes 2 □ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: AN Nursing Homa 5 Rasidenca 8 Other (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA

Physician /Medical Examiner

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Division of Vital Records, P.O. Box 68760.

Physician

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Examiner

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Director

7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examinar must be notified at

with the Maryland

death

parmit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" any injury or other traumatic averages.

Examiner Physician/Medical 2q Completed

To Certification:

exeminer?	ZES No	
27. Manner of	Death	

5 Pending investigation

6 Could not be datarmined

09

28a. Date of Injury (Month, Day Year)

28a. Placa of Injury - At homa, farm, straat, fectory, offica building, atc. (Specify)

28b. Time of

28c. Injury et Work? 1 ☐ Yes 2 ☐ No 28d. Dascribe how injury occurred

281. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifiar (Check only one)

1 Maturel

2 ☐ Accidant

3 ☐ Suicide

4 ☐ Homicide

Certifying Physician: To the best of my knowledga, daath occurred et the tima, date end plece, end due to tha causa(s) and mannar es steted.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, daath occurred et tha time, data and place, and dua to tha causa(s) and manner statad.

29b. Signeture and title of carifier

29c. Licansa number

29d. Data signed (Month, Day, Year)

30. Name end address of person who complated causa of deeth (item 23e) (Type, Print)

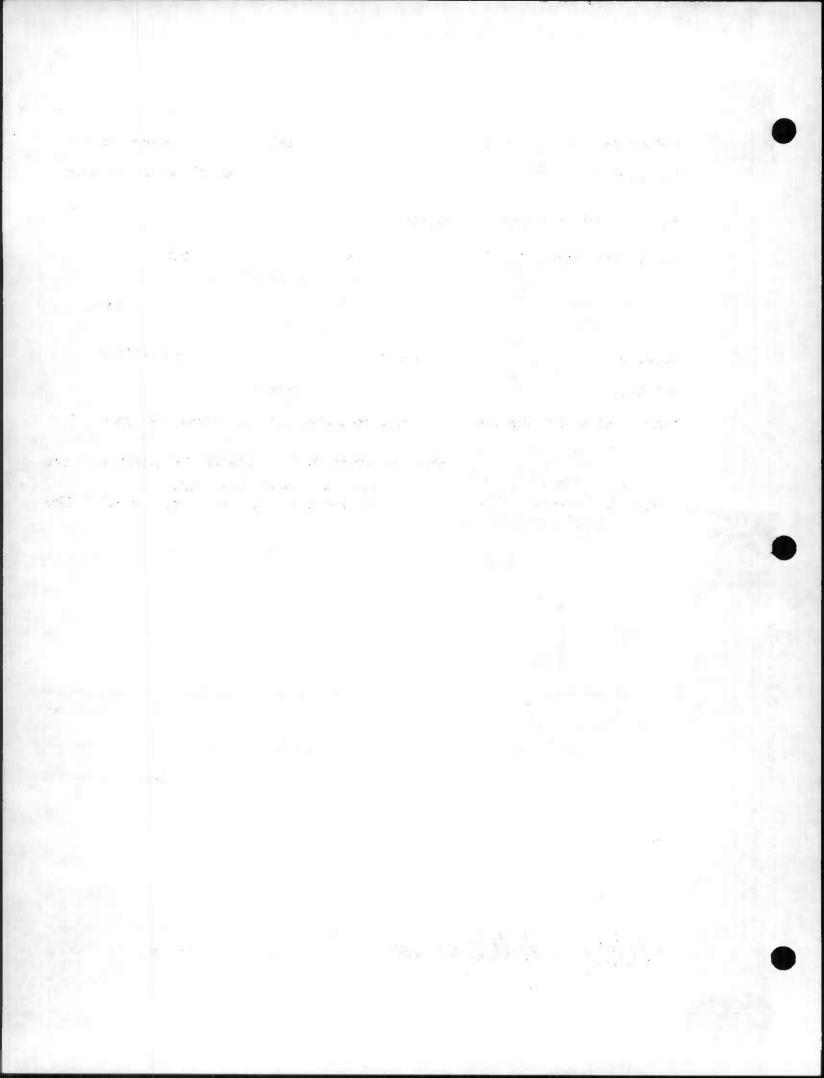
17. (Narren William 31. Data filed (Month, Day, Year)

FEB

MO 32. Registrer's Signeture

Prince George St. Laurel, 321

Registrar



99-0294-027 PETER WILLIAMS

Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No

ASP **Physician**

/Medical

Examiner

1. Decedent's Name (First, Middle, Last) Peter Clair Williams 2. Date of Death 19 1999 JANUARY

9:27 P 4c. County of Death

3. Time of Death

1 Yes 2♥ No

Funeral Director

notifie

"natural", or

permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiens. Important: If Item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa

Directo

Funeral

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Completed

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72 hours after death

Baltimore, Maryland 21215-0020

PROMISE COURT 5. Social Security Number

4a Facility Name (If not institution, give street and number)

7. Age (In yrs. last birthday) 18 M 2□ F

LAUREL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Days

4b. City, Town, or Location of Death

HOWARD Birthplece (State or Foreign Country)

USA

166-32-5533 **Usual Residence of Decede**

10a. State 10b. County MD Howard 10c. City. Town or Location Laurel

May 10, 1941 Pennsylvania 10d. Inside City Limits

10e. Street and Number

9742 Promise Court

10f. Zip Code 20723

10g. Citizen of What Country?

11. Marital Status

1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1960–64

 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:

14. Race - American Indian. Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

College (1-4or 5+) 4 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry United States Government

17. Father's Name (First, Middle, Last)

Joseph Williams

18. Mother's Name (First, Middle, Maiden Sumame) Margaret Russell

104-60 Queens Blvd, Apt 18P, Forest Hills, NY 11375

19a. Informant's Name/Relationship (Type, Print)

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Grace Washington /daughter 20a. Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place)

Systems Analyst

20c. Location - City or Town, State

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify)

Metro Crematory, Inc. 22, Name and Address of Facility

1/23/99 Catonsville, Maryland

21. Signature of Funeral Service Lin

Donaldson Funeral Home, P.A.

313 Talbott Ave. Laurel, Maryland 20707-4389 complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, and only one cause on each line. 23a. Part1. Enter the Approximate Interval Between Onset end Deeth

Physician /Medical Examiner

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To the Hospital of within 24 hours of To the Funeral Completely filled Hospital

The law requires that the daeth certificate be asscuted

Box 68760.

P.O.

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Division or Attanding Physician/Medical Examine

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events

that initiated events resulting in death) Last

Immediate Cause (Final disease or condition resulting in death)

CIRMHOSIA DE LIVER

Due to (or es a consequence of):

appour BICOMOULSM

Due to (or as e consequence of)

Due to (or es e consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown

24a. Was an autopsy performed?

PARTICI 1 Yes 2 No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical 1 XYes 2 No

3 ☐ Suicide

27. Manner of Death 5 Pending investigation 2 Accident

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide 29a. Certifier (Check only

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

6 ☐ Could not be

29c. License number O.C.M.E

29d. Date signed (Month, Day, Year) JANUARY 19, 1999

28f. Location (Street and Number or Rural Route Number, City or Town, State)

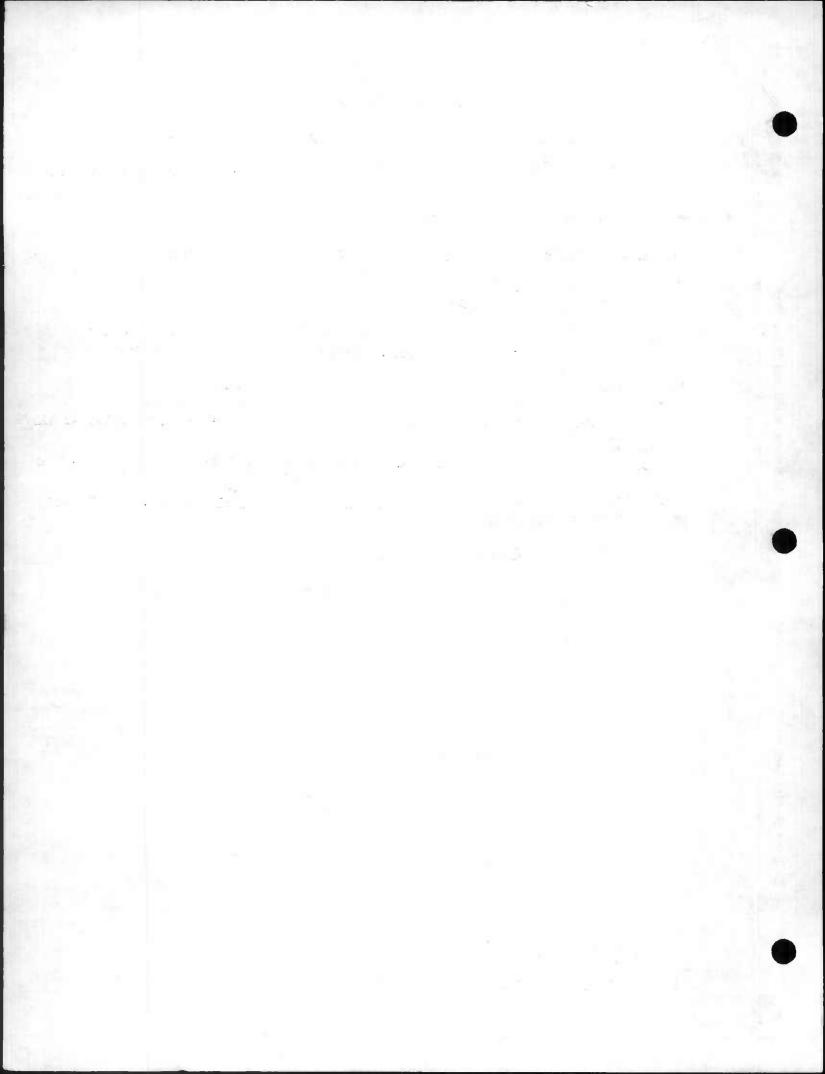
and address of person who completed cause of death (Item 23a) (Type, Print)

anna, (Consu dun 111 Penn Street, Baltimore, Maryland 21201

State Registrar

32. Registrar y Signéture 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Nor 1. Decedent's Name (First, Middle, Last) 2. Date of Death ANNE WILLIAM. adlity Neppe (If not institution, give street end number) 55 4b. City, Town, or Location of Death 4c. County of Deeth Ellicott Howard NUrsing City 7. Aga (In yrs. lest birthday) Yrs. If Under 1 Yaar If Under 24 Hrs. 5. Social Sacurity Number Birthplace (State or Foreign Country) Days 1□M 217F Pennsylvania Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Howard Columbia 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 6336 Cedar Lane 21044 United States 12. Was Decadent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Giva Yeer or Detas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Raca - Amaricen Indian, Bleck, Whita, atc. 1 Never Married 2 Married 1 Yas 2 No Specify: 3 XWidowed 4 ☐ Divorced White 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 2 Homemaker Own Home 17. Fether's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Michael Koscho Anna Kamarosky 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Nancy Grace/Daughter 10371 Painted Cup Columbia, Maryland 21044 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Ramovel from State 4 ☐ Donetion 5 ☐ Other (Specify) 1-25-99 Cumberland, Maryland Sunset Memorial Park 21. Signature of Funeral Sarvice Licensee 22. Name end Address of Fecility Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one ceuse on each lina. Approximete Intervel Between Onsat and Daath Lotage Col Due to (or es e consequence of): Due to (or es e consequence of): Due to (or es a consequence of): 23b. Did tobacco uee contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveilabla prior to completion of ceusa of deeth? 1 Yas 2 29No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

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ò Items 23a

traumatic event, the Medical Exerciner munt be notified at

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nd Mental Hygiene. marked other than

. Pages 1 end 2 should be filt ment of Heelth and Mental Hy lant: If Item 27 is marked oth jury or other traumatic event

permit. Page Department of Important: If any Injury or

with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0020

P.O. Box 68760.

Records,

Division of Vital

the burial-transit for use page 2 should be

á this certificate After

or Attending Physician: The law requires thet the death certificate be executed filled in by the funeral director, To the Hospital or Attend within 24 hours efter deeth To the Funeral Director: /

> State Registrar

31. Dete filed (Month, Day, Year)

Immediete Ceuse (Final disaase or condition resulting in deeth) Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Diseese or injury that initieted events resulting in deeth) Lest Part II. Other significant conditions contributing to deeth but not rasulting in the undarlying cause given in Pert I. by Completed 25. Wes case referred to medical exeminer? Be 26. Plece of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 🗆 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Descritifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end menner steted. (Check only one) 29b. Signature end title of certifier 29c. Licansa number 29d. Date signed (Month, Day, Year)

30. Name end address of parson with completed cause of deeth (Item 23a) (Type, Print)

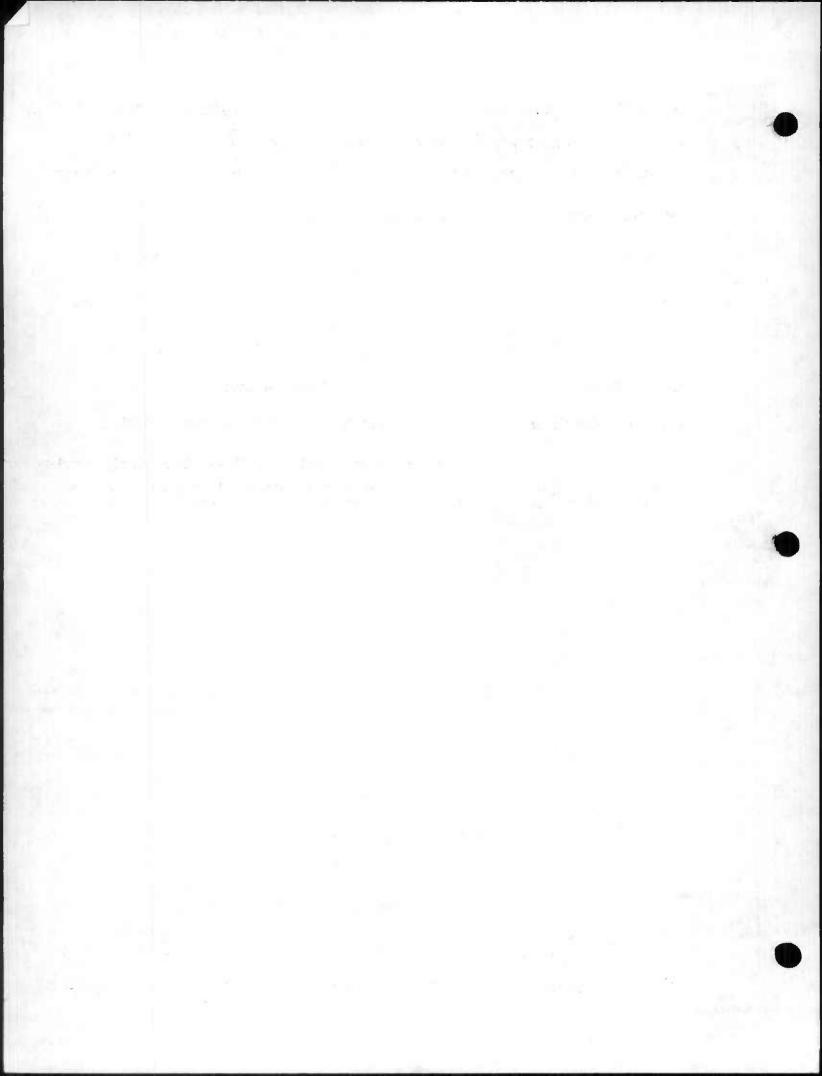
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DI. COLUMBIA MOZIOGES

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32. Registrer's Signeture



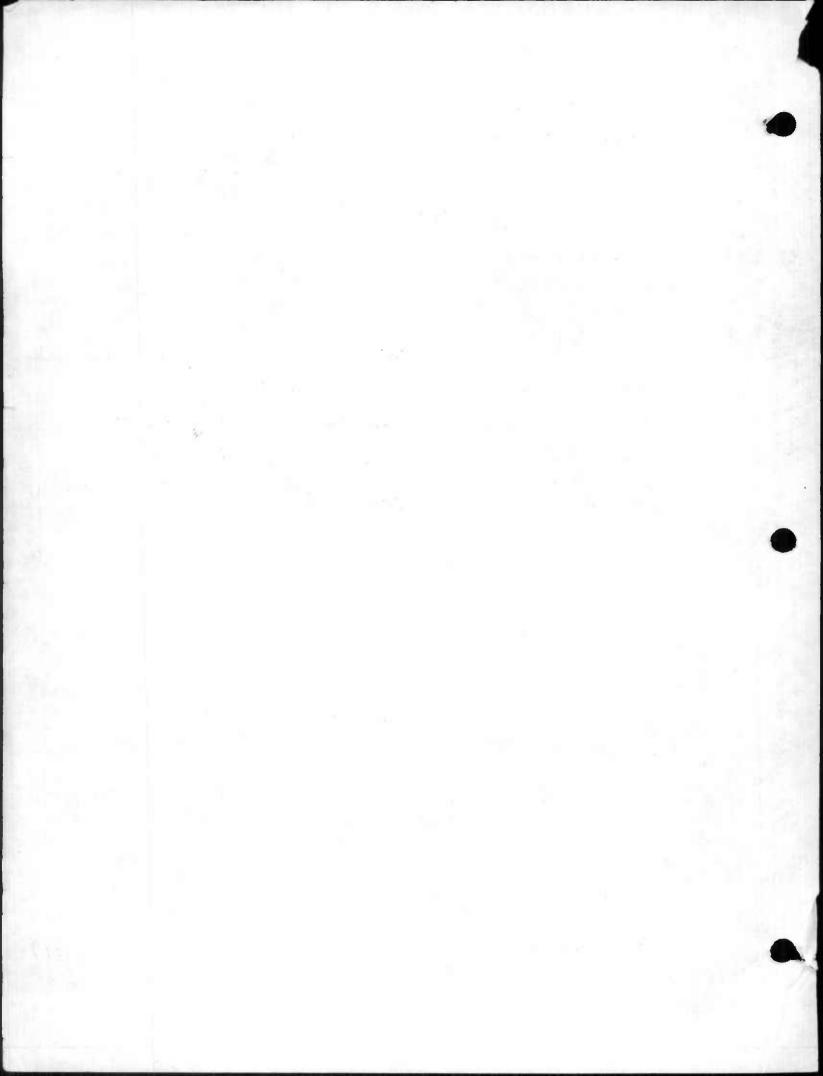
Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Month 3. Time of Deeth Year 9 29pm **Physician** EBRUARY 20, 1999 Nelson Kenneth Albiker /Medical 4c. County of Death 4e Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death / Examiner Stella Maris @ Mercy Hospital Baltimore If Under 24 Hrs. Hours Min. If Under 1 Year 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Deys Months 10 M 20 F 71 Director 215-22-JUNE 6, 1927 Maryland Usual Residence of Decedent filed within 72 hours after death with the Manyland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f ahow 1 ☐ Yes 2 ☐ No MD Anne Arundel Pasadena Director 10e Street and Number 10f Zip Code 10g. Citizen of Whet Country? 6 511 Sunset Knoll Road 21122 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 N Yes 2 No If Yes, Give Yeer or Detes: WWII 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☑ Divorced white Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed with nent of Health end Mentel Hygiene. Maryland Dry Dock 8 Welder Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Harry William Albiker Mary Christoph 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) itam 27 Sue Ann Neville - daughter 511 Sunset Knoll Road, Pasadena, Md. 20b. Piece of Disposition (Name of cemetery, cremetory or other piece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Removei from State 4 ☐ Donation 5 ☐ Other (Specify) 2/23/99 = 8 permit. Page Department of Important: I any injury o Baltimore Washington Cr. Laurel. Md. 21. Signature of Funerei Service Licensee 22. Name end Address of Fecility Gary L. Kaufman Funeral Home @ Meadowridge MP, Irc 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. elest 21075 **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhieted events resulting in death) Lest Due to (or es e consequence of): Box 68760. Physician/Medical the Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☑ Inknown Division of Vital Records. Completed by 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No certificata or Attanding Physician: Be 25. Wes cese referred to medical examiner? 26. Place of Deeth (Check only one) STE //A MARIS AT MERCY Other: 4 Nursing Home 5 Residence 8 Other (Specify) HOSPICE 1 Yes 2 No Medical Certification: To 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Death 1 Divelurel 2 Di Accident 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) ŝ 29b. Signeture end title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2

State Registrar

DHMH 16 Rev 6/95

BAltiMORE.

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middla, Last) Month Day Year 1528 1999 Gertrude Nadine Adams FEBRUAR 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death E1kton Union Hospital Cecil If Undar 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Dey, Year) Birthplaca (Stete or Foreign Country) Months Days 1 M 2 J.F 83 313-18-2423 NOV 6, 1915 Indiana Usual Residence of Deceden 10a State 10d. Inside City Limits 10h County 10c. City. Town or Location 1 Yes 2 No Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 711 Bouchelle Road 21921 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Year or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, While, atc. 1 Never Married 2 Married 1 Yas 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life, DO NOT usa retired) 16b. Kind of Business/Industry 15. Dacedant's Education (Specify only highast grede completed) Elementary/Secondary (0-12) Collega (1-4or 5+) Foster Parent Foster Children 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Lodie Davis Estella Tharp 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Robert A. Adams/husband 711 Bouchelle Rd. Elkton, MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burlal 2 🂢 Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc.2/19/99 Baltimore, MD 22. Name and Address of Facility Cremation Society of Maryland, Inc. 21. Signatura of Funeral Service Licensee 0 Wonald C Dawh McDonald 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the diseasa, or complications that ceusad the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or haart failura. List only ona causa on each line. Approximate Interval Between Onsat and Death occurdial Infarction Immediate Cause (Final disease or condition rasulting in daath) Sequentially list conditions, if any, laading to immadiata ceusa. Entar Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequanca of) Due to (or as a consequence of): Part II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? 1 Yas 2 1No 1 ☐ Yes 2 ☐ No 25. Was casa raferred to madicel examiner? 26. Placa of Daath (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Dascribe how Injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yas 2 No 2 Accident 3 Suicide 6 Could not be datarmined 28f. Location (Streat and Number or Rurel Route Number, City or Town, Stata) 28a. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify) 4 Homicida

Examiner The law requires that the death certificete be executed physician and the buriel-transit Division of Vital Records, P.O. Box 68760, for use es signed by the e is certificate has director, pege 2: or Attanding Physician: this funeral After effer dec.
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Physician

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permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mentel Hygiene. Important: If itsm 27 is marked other than "natural; or flems 23a or 28a-f ahov any injury or other traumatic event, the Modical Examples must be notified.

Physician

/Medical

Baltimore, Maryland 21215-0020

the Marylend

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Registrar

DHMH 16 Rav 6/95

29a. Cartifier

29b. Signature a

(Check only

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licansa number

29d. Data signad (Month, Day, Year)

44716

February 18, 1999

30. Name and address of person who completed ceusa of death (Item 23a) (Type, Print)

21921

w. Highst

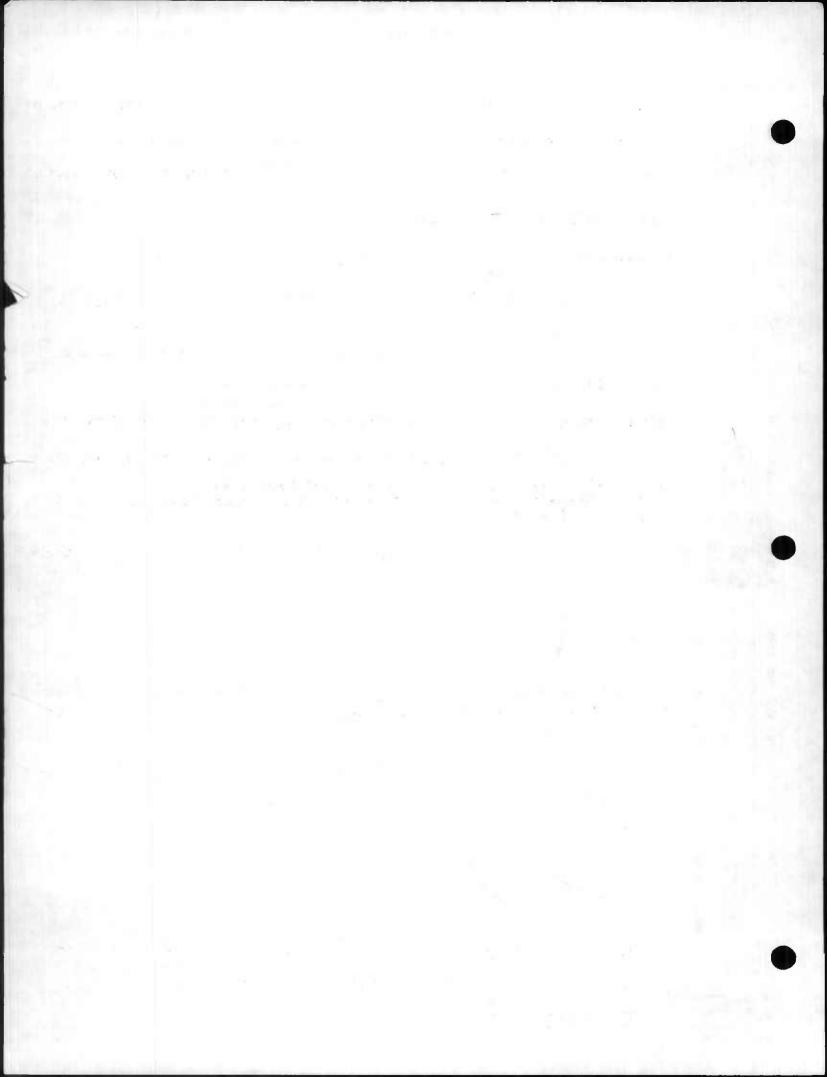
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32. Registrar's Sig

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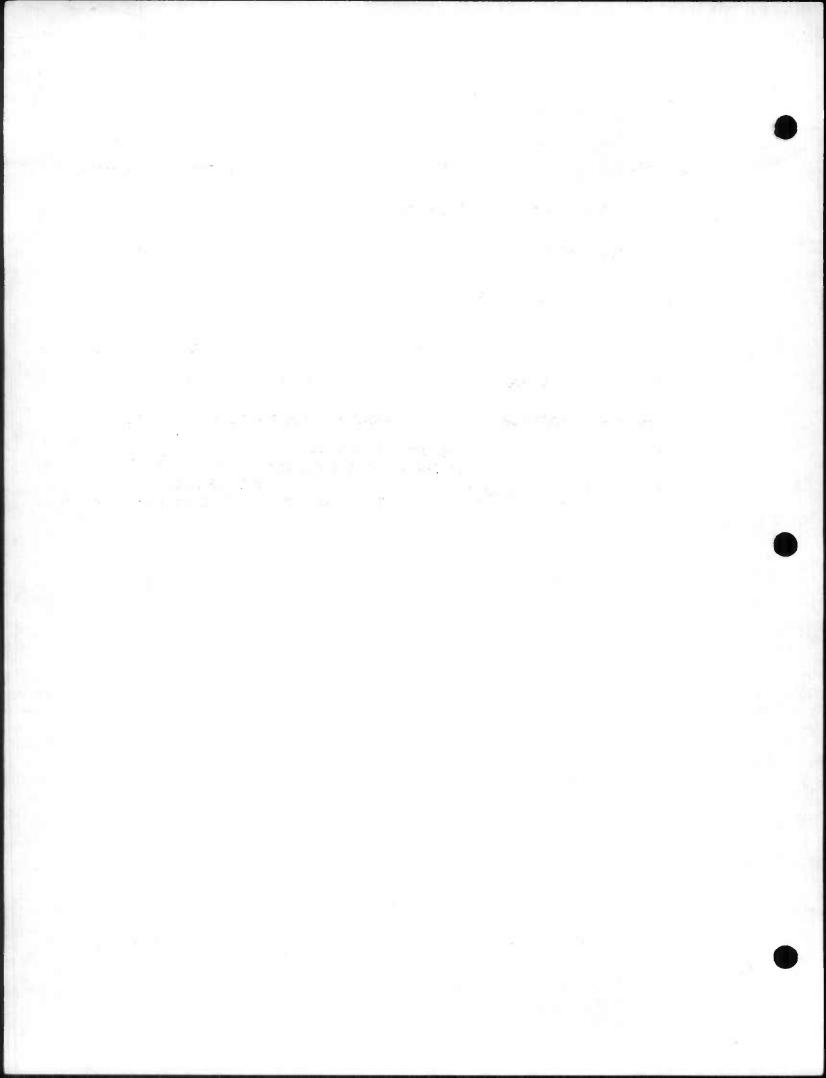
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		State of Maryla		tificate of		Re	g. No.	05	200		
Physician	Decedent's Nama (First, Middle, Last					Data of Death Month	Day 20, 19	999	8-Time of Death		
/Medical	Euva A.	Andrews			4b. City, Town, or Lo	February			9:30 pm		
Examiner	4a Facility Nama (If not institution, giva Heritage Nursino	The state of the s			Dundalk	Callori Oi Dealii	4c. County				
uneral	5. Social Security Number 6. Se		. lest birthday)	If Under 1 Year		8. Date of Birth (Month, Dey,			ce (Stete or Foreign		
rector	229–24–1018	□ M 20XF 8	8 Yrs.	Months Days	Houra Min.	Jan. 02,	1911	West	Virginia		
al, or items 23a or 23a-f show Examiner must be notified at by Funeral Director	10a. State 10b. County	10c. C	city, Town or Loc	ation				10d	I. Inside City Limits		
ctor	Maryland Baltimon	re Bal	timore						1 ☐ Yes 2 No		
Director	10e. Street and Number			10f. Zip Code		10	10g. Citizen of What Country?				
rai	418 Nollmeyer Road			21220			U.S.A	- Amaricen	Indian		
Funerai	11. Marital Status 1 □ Never Marriad 2 □ Marriad	12. Was Decedent Ever in ₹ Armed Forces? 1 □ Yas 2 ☒ No	If Yes, specify Cuban, Mexicen, Puerto F			Rican, atc.)		k, White, etc			
by	3K Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2 No	Specify:		Specify	White	9		
ted	15. Decedent's Edu (Specify only highest grad	ucetion	16a. Decede	ent's Usual Occup	eation during most of working)	1	16b. Kind of Business/Industry				
Completed	Elementery/Secondery (0-12)	College (1-4or 5+)									
	17. Father's Name (First, Middle, Last)		Dre	ss Maker	Clothing Company			npany			
Be	Thomas Robinett		18. Mother's Name (First, Middle, Maiden Surnema) Mattie Hicks								
To	19e. Informent's Name/Relationship (T)	vpe, Print)	19b. Meiling	Address (Street	end Number or Rure	l Route Number,	City or Town,	Stete, Zip C	ode)		
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	23a. Part1 Enter the disease, of comp shock, or heart failure. List only o	lications that caused the dea							Approximate Interval Between		
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al er	Immediate Cause (Final disease or condition resulting in death)	Serre	U @	ere	'c 54	Leus	75		years		
	resulting in death)	Due to	(or as a consequ	uence of):					0		
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edicai	Cause (Disease of Injury that Initiated events Due to (or as a consequence of):										
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enti	4 ☐ Hornicide determined building, etc. (Specify) City or Town, Stefe)										
	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.										
ledical	(Check only one) 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.										
Σ	29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year)										
	1008358 21 CUGG										
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GRACE (VATRICO) K403 HARECEO BOP BACE: CRACELLARD 2 (22)										
 State	31. Date filed (Month, Dey, Year)	32 Registrar's Sign		4	100 1	ME	071	10	74		
gistrar	FEB 2 3 1999	Serve	6.	hoad	,						
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death ADAMSKAYA Month Day 16, 1999 **Physician** TSILYA 1720 Hrs /Medical 4e. Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner RANDALLSTOWN NORTHWEST BALTIMORE HOSPITAL 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 83 Yrs. Months Days Hours Min. 129725/1915 5. Social Security Number 213–35–1482 9. Birthpleca (Stata or Foraign **Funeral** 1□M 2□F UKRATNE Director Usuai Rasidenca of Decedent the Marylend 10a. Stata 10b. County BALTTMORE 10c. City, Town or Location BALTIMORE 10d. Insida City Limits ortant: If item 27 is merked other than "natural", or items 23a or 28a-1 show injury or other traumatic event, the Maxical Examiner must be notified at 1 TYAS WYNO Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Coda permit. Peges 1 end 2 should be filed within 72 hours efter death with 1 Department of Health end Mental Hygiene. Important: If them 27 la merked other than "natural", or items 23a or any Injury or other traumstic event 21208 U.S.A. 1 GREENWICH PLACE Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedant Evar In U,S. Armed Forces? 14. Rece - American Indien, Black, Whita, atc. 1 Never Married 2 Married 1 ☐ Yas 2 ☑ No If Yas, Giva 🏠 Yaar or Datas: Specify: WHITE Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Elementery/Secondery (0-12) College (1-4er 5+) **ECONOMIST** DEPT. OF AGRICULTURE 17. Father's Name (First, Middla, Last) 18. Mother's Nema (First, Middla, Maldan Sumama) Be **ITSKO** ADAMSKIY ROZA MARKOVA 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) GREENWICH PLACE BALTIMORE MD 21208 RAISSA BARMAK/DAUGHTER 20a. Method of Disposition 20b. Plece of Disposition (Nama of 20c. Location - City or Town, Stete ARCTNOTON CEMETERY 1 Burial 2 Cremetion 3 Removel from State CHIZUK AMUNO CONGREGATION 2/18/99 BALTIMORE MD 4 □ Donetion 5 □ Other (Specify) 21. Signatura of Funaral Sarvice Licansaa 22. Nama and Addrass of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE MD 23e. Pert¹. Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intarvsi Between Onset and Death **Physician** SEPSIS /Medical Immediate Cause (Final diseese or condition resulting In death) Examiner PNEUMONIA Examiner BILATERAL Sequantielly list conditions, if sny, laading to immediata causa. Entar Undarfying Cause (Disaasa or Injury that Initieted evants rasulting in daath) Last Records, P.O. Box 68760. physician Physician/Medicai Dua to (or es a consequença of) Part II. Other significant conditions contributing to death but not resulting in the undarlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☑ Unknown þ 24b. Wara autopsy findings sveilabla prior to Completed 24e. Wes sn sutopsy performad? complation of cause of dasth? 2 No 1 ☐ Yas 2 ☐ No 1 Yas certificate Division of Vital or Attending Physician: 25. Was casa rafarred to medical examinar? Be 28. Placa of Death (Check only one) Hospital: 1 Ampatient 2 ER/Outpatient 3 DOA 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidance 8 Other (Specify) 2 this funeral 28c. Injury at Work? 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how Injury occurred Certification: After 5 Panding Invastigation 1 Naturel To the Hospital or Attendir within 24 hours efter death. To the Funeral Director: Af 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be determined 3 Suicida 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicida 1/ Certifying Physicisn: To the bast of my knowledge, deeth occurred at the time, date and place, and due to the csuse(s) and mennar es ststed.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifian Medical 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of cartifian 29c. License number FEBRUARY 16, 1999. 37333 30. Nama and addrass of person who complated causa of death (Itam 23e) (Type, Print) MD, NHC, BALTO. 32. Registrer's Signatura 31. Data filed (Month, Day, Yaar) State FEB 2 3 1999

Registrar **DHMH 16 Rsv 6/95**



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier 9 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death -Months 11:02 Al Lorena M. Adams 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death BALTIMORF SAINT AGNES HOSPITAL, 900 CATON AVE None | H Under 1 Year | H Under 24 Hrs. | 8. Data of Birth (Month, Dey, Yeer) | March 16,1925 7. Aga (In yrs. lest birthday) 9. Birthplace (Stete or Foreign 1□M 2\F 244-28-9662 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 TiNo Baltimore Maryland Baltimore 10e Street and Number 10f. Zip Code 10g. Citizan of What Country? 2405 Tionesta Road Apt 2D 21227 United States 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Surneme) David Smoot Sadie Durflinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rurel Route Number, City or Town, Steta, Zip Code) Russell N. Adams/Husband 2405 Tionesta Road Apt 2D Baltimore, MD 21227 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2-19-99 Glen Burnie, MD 22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Immediate Ceusa (Final ANOXI'C ENCEPHALOPATHY disease or condition resulting in death) END STAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown SeizuH 24b. Were eutopsy findings available prior to completion of causa of death? 24a. Was an autopsy 1 □ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Naturai 2 Accident 5 Pending investigation 1 Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r than "naturel", or items 23s or 28s-f ehor the Medical Examiner must be notified at

Hygiene.

permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked or

altimore, Maryland 21215-0020

Directo

Funeral

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Examiner Physician/Medicai 94

by

Completed

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2

edicai

State Registrar 29b. Signature and title of certifiar Keeluay). Ellervii

6 Could not be determined

29c. Licansa number P-11710

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signad (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Name and eddress of person who completed cause of deeth (Hem 23a) (Type Print)
Rodney S. Zancevica Saint Agnes Hospital, 900 Caten Are, Baltimore
40021229

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

3 ☐ Suicide

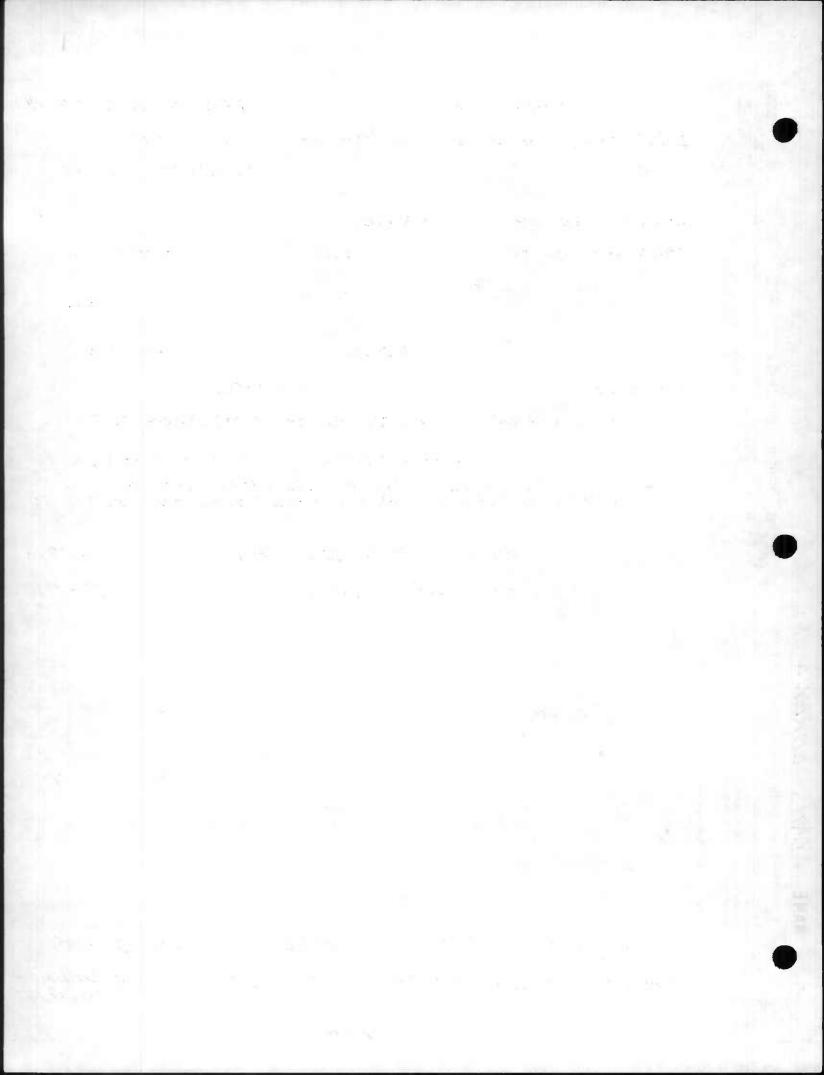
29a. Certifier

4 Homicide

FEB 23 1999

Serve G. Sparks

To the Within 2 To the



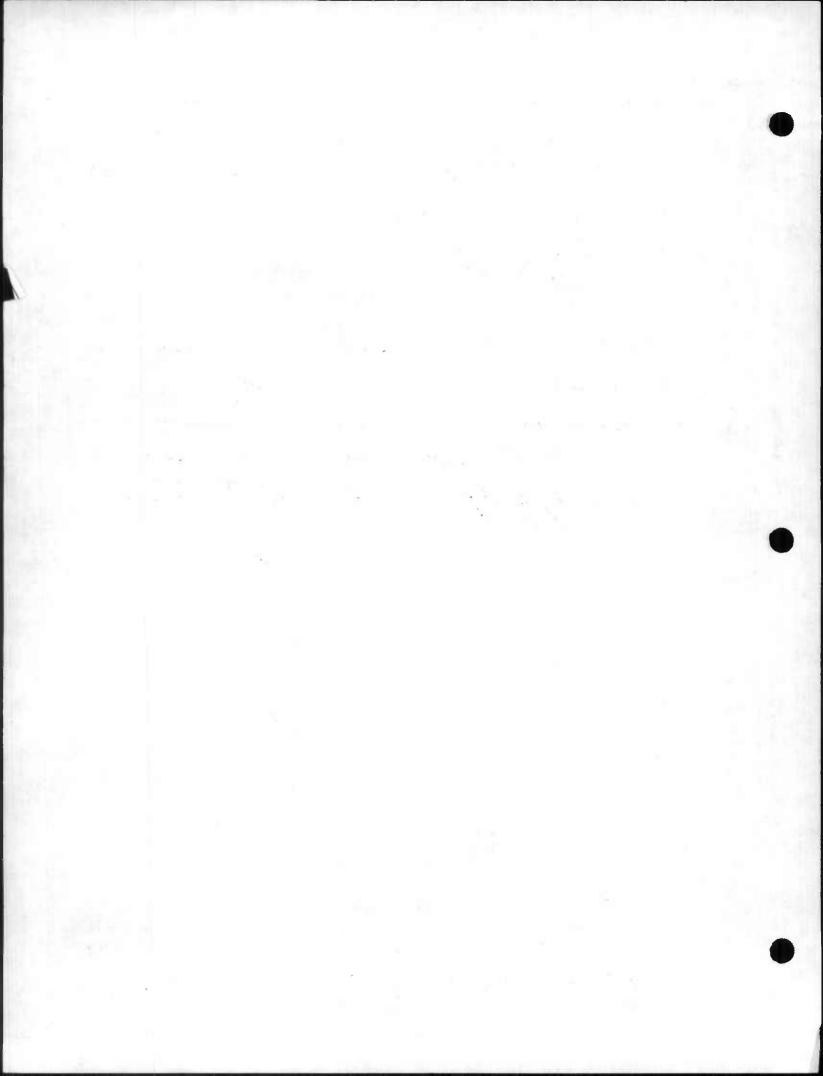
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month February Dey 1999 **Physician** Louise Mary Bryant 5:00 PM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Sunrise Of Towson Baltimore Towson If Under 1 Yeer If Under 24 Hrs. Hours Min. 5. Sociel Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) **Funeral** 1□M 21 F 081-03-7121 Director Aug. 12 1908 90 Maryland Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at NC 1 ☐ Yes 2 No Director Southern Pines 10e Street and Number 10f. Zio Code 10g. Citizen of Whet Country? 1150 Central Dr. 28387 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien. 11 Merital Status Bleck, White, etc. filed within 72 hours after Hygiene. 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Merried 2 Merried 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify p 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Self Employed Business Owner 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be filt.
Department of Health and Mentel Hy
Important: If item 27 ie marked other
any Injury or other treumatic event Be Ermindo Barsotti Anna Cirillo 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Teresa Farace/Niece 1605 Randallwood Ct. Jarrettsville, MD. 21084 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Moreland Memorial Park 2-23-99 Parkville, MD. 21. Signature of Funeral Service Lices 22. Name end Address of Fecility
Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204 cutions that couled the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, to cause on each line. 23a. Part1. Enter the disease, or conshock, or heart feilure. List Approximate Intervel Between Onset end Deeth Physician /Medical Immediate Cause (Finel spenosis disease or condition resulting in deeth) 25 years Examiner Physician/Medical Examiner Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or as e consequence of): P.O. Box 68760, Due to (or as e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Dfd tobacco use contribute to the cause of death? signed by the 1 TYes 2 No 3 Probably 4 ☑ Unknown ontrolled heart failure mild Records, by 24b. Were eutopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes an autopsy performed? ane mig 1 Yes 2 No 1 ☐ Yes 2 ☑ No Division of Vital Hospital or Attending Physicien: 24 hours efter death. Funeral Director: After this certification by the funeral director, g 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Neturel 5 Pending investigation 1 Yes 2 No NA 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours e To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the cause(s) end menner stated. edicai 29e. Certifier 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 22.99 (in 30. Name end address of parson who completed cause of deeth (Item 23a) (Type, Print) took up WSON MAD Z1204. York 20 32. Register's Signeture 31. Dete filed (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar

1999

FEB 23



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien (Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year 210 Vicki Lynn Baroch FEB 1999 pru 18 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore If Under 24 Hrs. 8. E Hours | Min. (6 St. Agnes Hospital 5. Sociel Security Number 6. Sex If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Deys Months 10 M 20 F 217-90-9537 33 JUNE 3. Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore County Catonsville 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 21228 USA 405 Greenlow Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11 Meritel Status 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Merried 2 Merried 1 Yes 2 No Specify Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 10 Craftsman Press Inspector 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Eugene Gillespie, Sr. Sally Garland 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Sally Gillespie - mother 927 Brunswick St., Balto., Md. 21223 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 2/22/99 Baltimore Washington Cr. Laurel, Md. 22. Neme end Address of Fecility 21. Signeture of Funeral Service Licensee Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreshock, or heart failure. List only one ceuse on each line. immediate Ceuse (Final Corebral edemo disease or condition resulting in deeth) encephalopath Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy 1 Yes 2 No 1 Yes 2□ No 25. Wes case referred to medical 26. Piace of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 28e. Date of injury (Month, Dey Year)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Be

Funeral

Director

288-1

'natural', or items 23s or

Hygiene.

Department of Health and Mental Fireportant: If Nem 27 is marked oft any Injury or other transcript of

altimore, Maryland 21215-0020

Physician/Medical by Completed Be Certification: To

attending physician and for use as the burial-tran P.O. Box 68760, signed by t certificate or Attending Physician: After death. Director: the Funeral Dire hours within 24 hor To the Fr

Records, Division of Vital

2

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AM

State Registrar

Medical

1 ANaturel 2 Accident

3 Suicide

29a. Certifier

4 Homicide

29b. Signature and the of certifier

5 Pending investigation

6 Could not be

2201

29c. License number

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Day, Year)

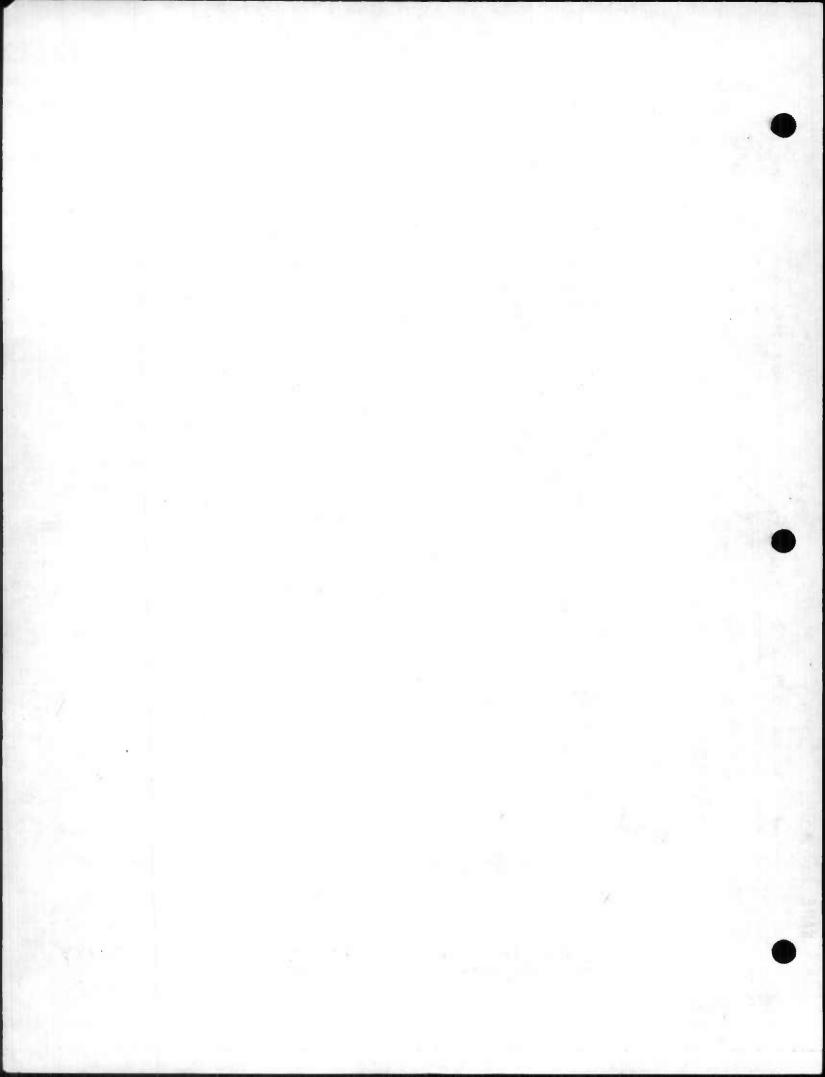
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

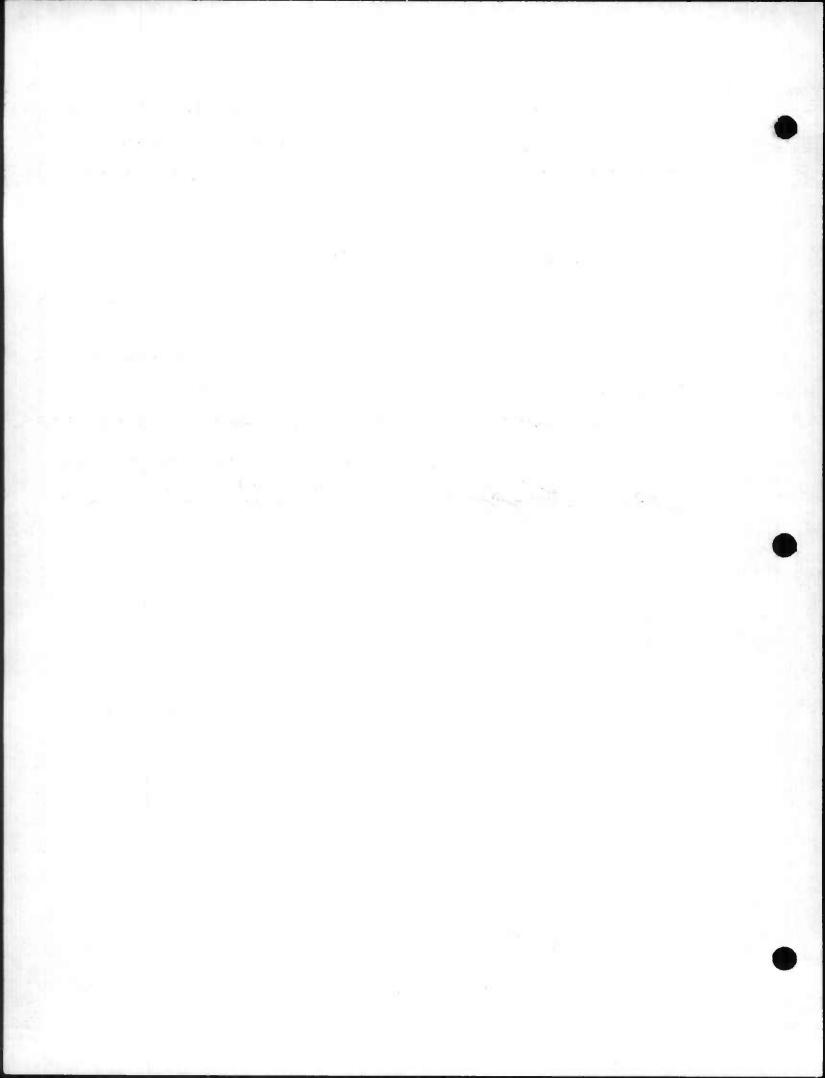
DRANNEREED ST ABNES HEATNCARE BALTIMORE, MD 21224 31. Dete filed (Month, Day, Year)

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrer's Signeture 1999 FEB 23



Funeral Director Funeral Director	Henry	7	Banz				2. Dete of Deeth Month	_	Yeer	Time of Death	
Examiner Funeral Director Director	4e. Fecility Neme Solomo 5. Sociel Security						Feb 21,	1999		4 PM	
Pirector	Solomo	in their members in		ver)		4b. City, Town, or Lo		4c. County		4 PM	
or 28s-1 show be notified at Director	5. Sociel Security	ns Nur	SSOLVILLION III			Solomon					
or 28s-1 show be notified at Director	213-03-			Age (in yrs. lest birthdey)	If Under 1 Yeer	MILE AND AND AND AND AND AND AND AND AND AND			ce (Stete or Forei		
ms 23e or 28e-1 show must be notified at eral Director	Usual Residence		1 ½ M 2□ F	88 Yrs.	Hours Min.	oct. 22,	1910	Maryla	ind		
ns 23s or 28s-f	10e. Stete	10b. County			Oc. City, Town or Location						
must be no eral Dire	Maryland Calvert Lusby									1 □ Yes 22016	
ns 23s	10e. Street end No				10f. Zip Code 20657			g. Citizen of V	Whet Country	?	
2 4 0	11600 Bi	g Bear L	7				.S.A.				
s 1 and 2 should be filed within 72 hours effer death with the Maryland f Heelih and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Examination and traumatic event, the Medical Examination at To Be Completed by Funeral Director	3 ☐ Widowed	ried 25 Merrie	12. Wes Decede Armed Force 1 Yes 2 If Yes, Give Yeer or Date	⊠ No	Was Decedent of Hispenic Origin? (Specify Yes or If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:		cify Yes or No- Rican, etc.)	14. Rece - American Indian, Bleck, White, etc. Specify: White		3.	
	(Spe Elementery/Sec	15. Decedent's Education 15. Decedent's Education 15. Decedent's Education 15. Decedent's Education 16. College (1-4or 5+) 16. College (1-4or 5+)		or 5+)	16e. Decedent's Usuel Occupetion (Give kind of work done during most of w life. DO NOT use retired) Truck Driver		16b. Kind of Business/				
d other event, Be C		(First, Middle, La	st)	illuc	Y DIIVEL	18. Mother's Neme				11	
Menta Brked atic ev	Bernard	W. Ban	Z			Margaret	Pehrin	ger			
is marked of raumatic eve	19e. Informent's N	leme/Reletionship	(Type, Print)	19b. Melilin	g Address (Street	end Number or Rura			State, Zip Co	ode)	
Depertment of Heelth enc important: If Item 27 is n any Injury or other traun ance.	Judith M	arie Siw	inski (da	ughter)1100	Berryman	s Lane, Re	eisterst	own, M	arylan	id 21136	
of He de	20e. Method of Dis			20b. Plece of Dispo	sition (Neme of netary or other pie	ce)	Dete 2	0c. Location -	City or Town	ı, Stete	
int: If its		Cremetion 3 5 ☐ Other (Spe	☐Removel from Ste city)	Green Mou			/24/99 Baltimore, Maryland				
ortai inju	21. Signature of F								20, 120	L J Luna	
Deperiment in any ir	10/2	-7	Tunk			ski Funera				7 010	
	23s Pert1, Enter	the disease, or or	molications they cau			Eastern Av					
Physiclan	shock, or he	Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardled or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Betwee Onset and Dea									
Medical	Immediate Course (Final										
aminer	disease or condition resulting in deeth) e. CANCER OF PROSTATE WITH METS m Due to (or es a consequence of):								Shows		
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physicia s the bur edical	Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Couse (Disease or Injury that infilited events Due to (or es e consequence of):										
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page 2 should	performed? co					comp of de	able prior to eletion of cause eth?				
age 2							1□ Ves	2 ■ No		res 2□ No	
	25. Was case refe	rred to medical				26. Plece of Deeth				65 ZLI NO	
Il director	examiner?		Hospitel: 1 ☐ inp	atient 2 ER/Outpatlen	t 3 DOA Oth	ner: 45 Nursing Hon			er (Snecihi)		
eral c	27. Manner of Dea		28a. Dete of I	njury 28b. Time of	28c. Injur		28d. Describe hov				
After a funer	Naturel 2 Accident	5 Pending investigat		Dey Year) Injury		rk? IYes 2□No	- Trace and the control of the contr				
rs effer death. al Director: Affer led in by the funer Certification:	3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office						28f. Location (Street and Number or Rural Route Number,				
Direction of the property of t	4 Homicide	Gotomini	building,	etc. (Specify)			City or Town,	Stete)			
within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29e. Certifier (Check only one)	1 Certifying 2 Medical Ex	Physician: To the be aminer: On the basis and menner	st of my knowledge, deeth s of examinetion end/or inv steted.	occurred et the tir restigetion, in my o	me, dete end plece, e opinion, deeth occurre	and due to the cau ad et the time, del	use(s) end ma te and plece, o	nner as stete end due to th	ed. e cause(s)	
omp omb	29b. Signeture end	title of certifier	TA1 -		29c. Licens	se number	29	d. Date signer	d (Month, Da	y, Year)	
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	Scaria 31. Dete flied (Mon			1910 H.G.	Trueman	n Rd. Lu	sby Mar	yland	206	57	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Dey 1999 Year MARY GERTIE BRADFORD Feb 20, 10:15 am. 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 1827 Belt St. Baltimore City N/A 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days 1 □ M 200 F 224-03-6548 Yrs. 24 1909 Alabama Usuel Residence of Decedent 10b Counts 10c. City, Town or Location 10d. Inside City Limits N/A Baltimore 1X Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1827 Belt St. 21230 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ②☐ No If Yes, Give Year or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian, Bleck, White, etc. 11. Marital Stetus 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 XWidowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ollie Love Mary Dorman

20b. Plece of Disposition (Name of cemetery, cremetory or other place)

Crestlawn Mem. Gdns.

22. Name end Address of Fecility

Congestive heart failure

28c. Injury et Work?

29c. License number

023624

1 Yes 2 No

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)

2/23/99

McCully-Polyniak Funeral Home, P.A. 130 E. Fort Ave., Balto., Md. 2123

2131 Doral Drive, Tallahassee, Fla.

Physician /Medical

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

10a Stete

Md.

9

20e. Method of Disposition

Immediete Ceuse (Final

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury thet Initieted events resulting in death) Lest

25. Was case referred to medical exeminer?

1 ☐ Yes 2 No

27. Manger of Deeth

diseese or condition resulting in death)

19e. Informent's Name/Reletionship (Type, Print)

1 Burial 2 ☐ Cremation 3 ☐ Removal from State

(son)

Kevin E Ecker

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

cerebro vascular accident

Hospital:

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line.

Due to (des e consequence of)

Due to (or es e consequence of):

Due to (or es e consequence of):

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b Time of

Larry C. Bradford

4 ☐ Donetion 5 ☐ Other (Specify)

21. Signeture of Funeral Service Licensee

Funeral

Director

"natural", or items 23s

The Medical

the Maryland to or 28a-f show

death with

filed within 72 hours after

Hygiene.

It of Health end Mentel Hygin If Itam 27 Is marked other or other traumatic event,

Depertment of Important: If any injury or once.

Pages 1 and 2 should be nent of Health and Mentel

21215-0020

Baltimore, Maryland

Examiner

The law requires that the deeth certificete be executed the buriel-transit Box 68760, Physician/Medicai USB BS P.O. Records, à should be Completed page 2 certificate of Vital Be

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I Certification: To Division 1 Naturel 5 Pending investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end manner stated. Medical 29e. Certifier 29b. Signeture end fitle of certifier 30 Name end address of person who completed cause of deeth (Item 23e) (Type, Print) 1000 Crain they sente 201 31. Dete filed (Month, Day, Year) State Registrar **DHMH 16 Rev 6/95**

32. Registrar's Signeture

28a. Dete of Injury (Month, Dev Year)

29d. Date signed (Month, Dey, Year) Feb 23, 99

28f. Location (Street and Number or Rural Route Number, City or Town, State)

20c. Location - City or Town, Stete

Marriottsville, Md.

23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

24a. Wes en eutopsy performed?

Other: 4 Nursing Home 5 PResidence 6 Other (Specify)

1 ☐ Yes 2 ☑ No

28d. Describe how injury occurred

Approximete Intervel Between Onset end Deeth

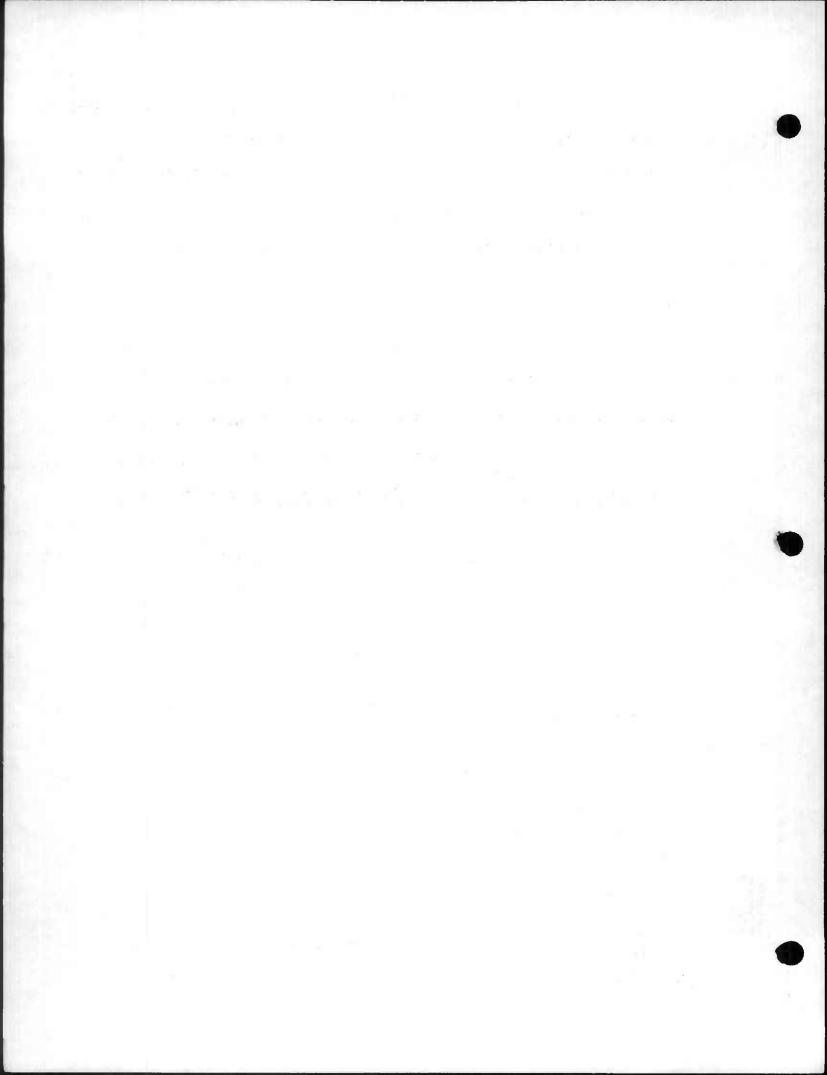
one day

24b. Were eutopsy findings eveileble prior to completion of cause of death?

1 ☐ Yes 2 ☑ No

aben Buni md 21061

26. Place of Deeth (Check only one)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month MILTON 6:30 p.M TEBRUARY 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hunder 24 Hrs. 8. Date of Birth Month Day Year 1929 HARBOR HOSPITAL LENTER N/A 5. Social Security Number 9. Birthplace (State or Foreign Country).
Virginia 7. Age (In yrs. last birthday) Days 120 M 2□ F Months 69 217-24-3683 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Pasadena 1 Yes 2 No Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 674 209th Street 21122 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No 195 If Yes, Give Year or Dates: 1 9 5 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, 11. Meritel Stetus Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married 1951 1 Yes 2 No Specify: Specify: White 3 ₩idowed 4 Divorced 1953 16a. Decadent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Civil Engineer Engineering Co. 12 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Elizabeth A. Whitfield William Herbert Booth 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 674 209th Street Pasadena, Maryland 21122 Daughter Cathy Weyant 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removel from State Crownsville VA Cemetery Feb. 22, 1999 Crownsville, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility McCully-Polyniak Funeral Home, P.A. 21. Signeture of Funerel Service Licensee 23a. Ped. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediete Cause (Final diseese or condition resulting in deeth) KES PIRATORY Due to (or as a consequence of) YSTOL Due to (or as a consequence of) OXIC ENCEPHALOPATHY

Physician /Medical Examiner

physician and s the burial-trans

signed t

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

10a State

Funeral

Director

28a-f show

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Barns 23a

permit. Fages 1 and 2 should be filed within 72 hours after. Department of Health and Montal Hygients. In them 27 is mented other than "natural any injury or other transmission of the state."

Baltimore, Maryland 21215-0020

Directo

Funeral

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Completed

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Examiner Cal

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated successions)

resulting in death) Last	d				1			
Pert It. Other significant conditions of	ontributing to death but not re-	sulting in the underlying	cause given in Pert I.	23b. Did tobacco use co	antributa to the cause of death? 3 □ Probably 4 □ Unknow			
				24e. Wes en eutopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?			
25. Wes case referred to medical	26. Place of Deeth (Check only one)							
examiner?	Hospital: 1 Dinpatient 2	☐ ER/Outpatient 3☐ [OOA Other: 4 Nursing	Home 5 Residence 6 □Oth	ner (Specify)			
27. Menner of Death 1 Neturel 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how Injury occurred				
3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, Stete)				
				e, end due to the cause(s) and m curred et the time, date end plece,				
20h Signature and title of certifier		2	9c License number	29d Date sinns	od (Month Day Year)			

State Registrar

SOUTH 32. Registrar's Signature

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

GANTI

31. Dete filed (Month, Day, Year)

EB 2

STREET, HANDVER

P17795

BALTIMORE.

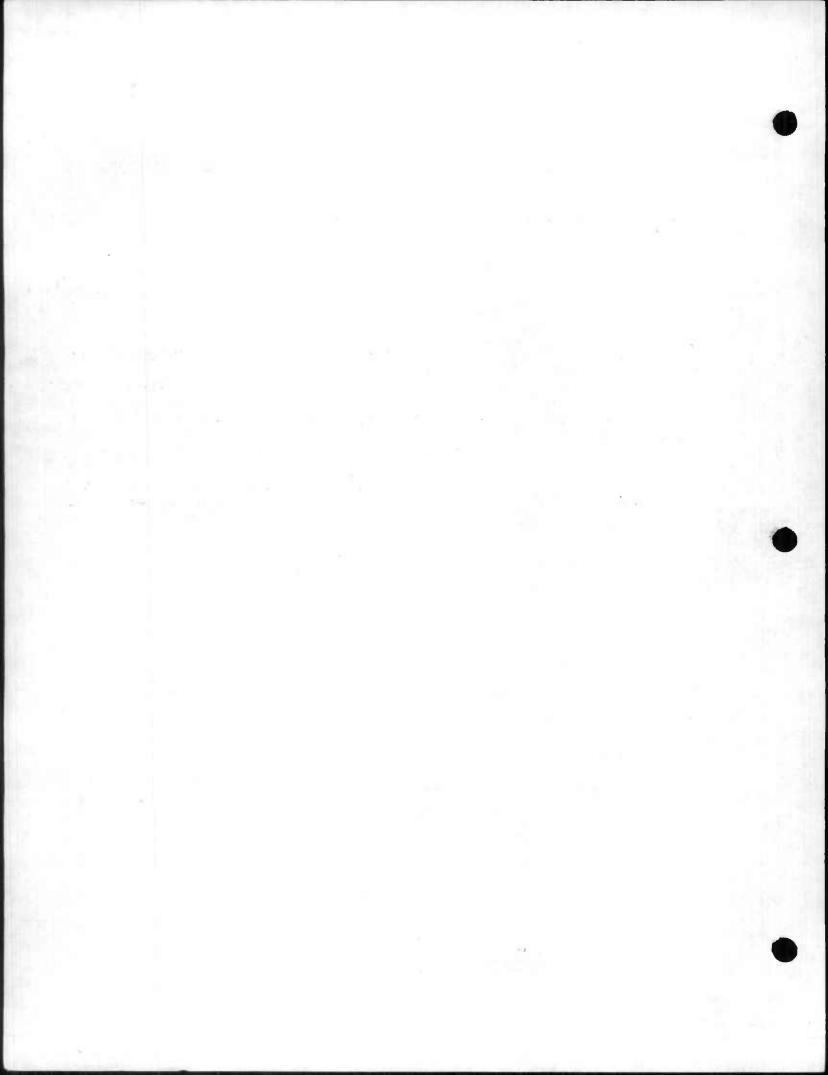
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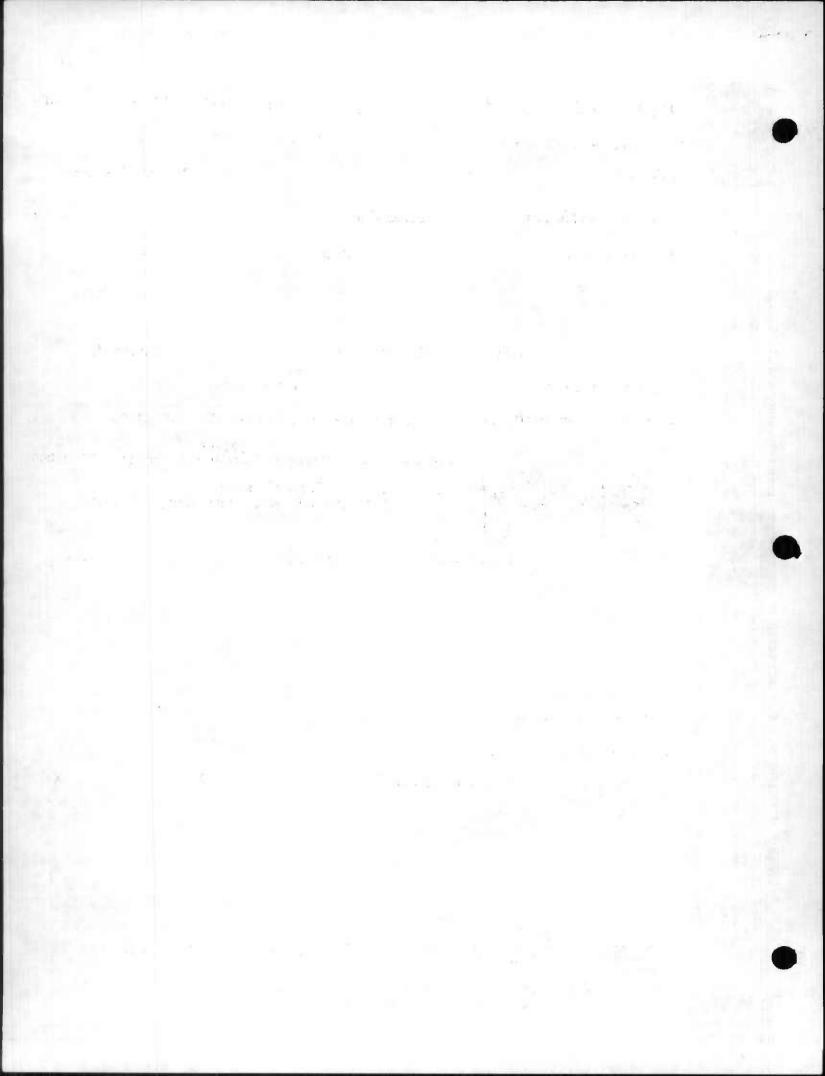
To the Mospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun



Please Type or Print In Black Indelible ink. Assure All Copies Are Legible.

)		e of Death	2. Dete of De			Time of Death
MAXINE	EVA	В	OUTWEL	FEBRUA	RY T8 19	0	8:00PM
4e Fecility Neme (If not institution, give	street end number)			or Location of Deeth	4c. County	of Deeth	
THE JOHNS HOPKINS		Williams	BALTIMO:		n/a		
5. Social Security Number 369-12-2005 Usual Residence of Decedent	7. Age (In yrs	Yrs. If Under Months	1 Year If Under 24 H Deys Hours M	n. (Month, De	y, Year) 29, 1923	9. Birthplece Country) Michic	(Stete or Foreign jan
10a. State 10b. County	10c. C	ity, Town or Location				10d. lr	side City Limits
MD Baltimo	re	Lutherville				1	□ Yes 2 📉 No
10e. Street and Number		10f. Zip	Code		10g. Citizen of V	Vhet Country?	
115 Belmore Road			21093		USA		
MD Baltimo 10e. Street and Number 115 Belmore Road 11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in the Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Yeer or Detes:	J,S. 13. Was Deced	dent of Hispenic Origin? city Cuben, Mexicen, Pu	(Specify Yes or No erto Ricen, etc.)	- 14. Reco	e - American In k, White, etc. : Whit	
15. Decedent's Edu (Specify only highest gred	cation	16e. Decedent's Usua	al Occupation rk done during most of v se retired)	vorkina	16b. Kind of Bu	siness/Industry	1
Etementary/Secondary (0-12)	College (1-4or 5+)				Moto	rcycle	
12 17. Fether's Name (First, Middle, Last)	n/a	Co-Propri		leme (First, Middle,			
Edward Shelberg			Anna	Roper			
19a. Informent's Name/Reletionship (T) Robert Roy Bout			re Rd., Lu				9)
20e. Method of Disposition 1X Buriel 2 Cremation 3 CF		Plece of Disposition (Ner cemetery, cremetory or c	ne of other place)	2/22/99	20c. Location -	City or Town, S	Stete
4 □ Donetion 5 □ Other (Specify)	Di	ulaney Valle	y Memorial	Gardens	Timoniu	um, MD	21093
21. Signatury of Funeral Service Licens	of Cont	22. Neme er	on Funeral	Home			
Bryan W. Cla	ary	10 W.	Padonia Ro	I., Timor	nium, MI	21093	
23a Part1 Priter the liseese, or complete the	icetions that caused the dea ne ceuse on each line.	ath. Do not enter the mod	le of dying, such es card	iac or respiretory e	rrest,	Inte	roximete rvel Between set and Death
Immediate Cause (Pinel			1 ^ -			Olis	A and Death
diseese or condition resulting in deeth)		nary En	uslism			82	lays
MECHANICAL STREET	Due to	(or as e consequence of):				1	
Sequentially list conditions	b	(or as e consequence of):				1	
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury						1	
thet initiated events resulting in deeth) Last	Due to (or es e consequence of):				9	
	4						
Part II. Other significant conditions con	ntributing to death but not re	sulting in the underlying o	euse given In Pert I.		tobacco usa co		
		sulting in the underlying o	euse given In Pert I.		tobacco usa co Yes 2 No		cauea of death?
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Part II. Other eignificant conditions con HYPER KALEM ACUTE LEWA	L FAILUR	E	ceuse given In Pert I.	1 D	Yes 2 No en eutopsy rmed?	3 Probably 24b. Were a eveilable comple of death	utopsy findings le prior to tion of cause
Parl II. Other aignificant conditions con HYPER KALEM ACUTE LEWA URINARY TRA 25. Was cese referred to medice!	LFAILUR	E		1 ☐ 24e. Wes perfo	Yes 2 No en eutopsy med? Yes 2 □ No	3 Probably 24b. Were a eveilable comple	utopsy findings e prior to tion of cause
Part II. Other significant conditions con HYPER KALEM ACUTE LEWA VRINARY TRA 25. Was case referred to medical exempine?	L FAILUR	E	26. Piece of I	24e. Wes perfo	Yes 2 No en eutopsymmed? Yes 2 □ No one)	3 Probably 24b. Were a eveilable comple of death	utopsy findings le prior to tion of cause
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2 Dete of Death 3 Time of Death FEBRUARY DE **Physician** 17 1499 11.18 Pm Neville Anthony Blake /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner ANNE ARUNISEL GLEN BURNIE NORTH-ARKINGEL HOE RITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 157 M 2□ F 131-50-5915 83 Yrs Director Sept. 25,1915 Trinidad Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Director 1 ☐ Yes 2 ☑ No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 7575 East Howard Road items 23a 21061 Trinidad Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married "netural", or 1 ☐ Yes 2 ☐ No Specify: Black Specify: þ 3 Widowed 4 ☐ Divorcad Completed 15. Decadent's Education (Specify only highest grade com 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry important: If Item 27 is marked other than Elementery/Secondery (0-12) College (1-4or 5+) Tailor 12 4 Clothing 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 end 2 should be f Health end Mental I Samuel Blake Laura Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jannette B.Blake - Daughter 7950 Jasons Landing Way, Severn, MD 21144 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State o 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Injury or Depertment 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 02/22 Baltimore, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 23a. Part1. Enter the disease or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, interval Between conset and Death **Physician** Immediate Cause (Final disease or condition resulting In deeth) /Medical ACP, ZATION Examiner Due to (or as a consequenca of): DEMENTIA burial-transit the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last Due to (or as a consequence of) Bud physician Physician/Medical Due to (or as a consequenca of): USB 0 Part II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes en autopsy performed? Completed peen 200 page 2 1 Yes 2 No 1 Yes 2 Wo 25. Was case referred to medical exeminer? 26. Place of Death (Check only one)

Box 68760. P.O. Division of Vital Records, certificate al or Attending Physician: T s efter death. Il Director: After this certificel ed in by the funeral director, p

e Funeral DI

Certification: To

Be

1 Yes 2 No

5 Pending investigation

6 Could not be determined

27. Manner of Death

1. Natural

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

31. Date filed (Month, Day, Year)

FEB 2 3 1999

within 2

Hospital

State Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end placa, and due to the cause(s) and manner stated. 29b. Signature and fills of certifier

Hospital: 1 Inpetient

28a. Date of injury (Month, Day Year)

MD

2 ER/Outpatient 3 DOA

28b. Time of

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 Yes 2 No

28c. Injury et Work?

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d Date signed (Month, Day, Year)

MD 21061

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

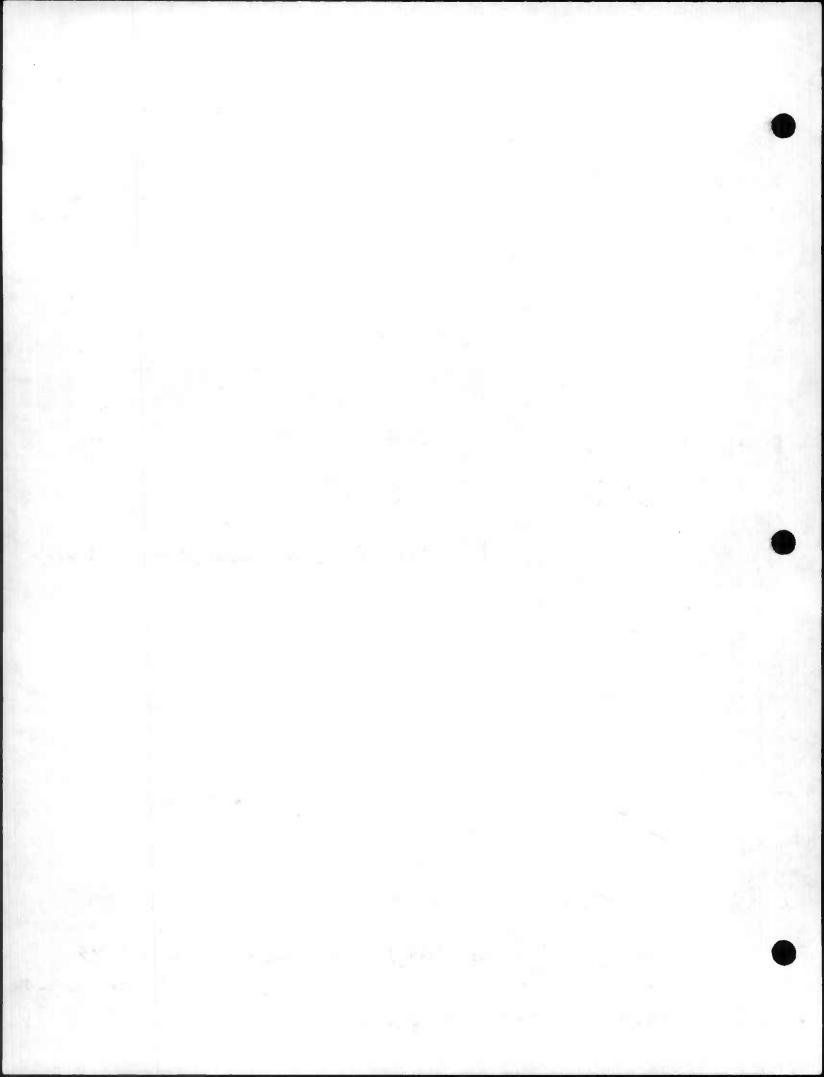
301 HOSPITAL DRIVE GLEN BURNIE ONLAB'A

32/ Registrar's Signeture

and the second of the second o and the state of the state of 45 / Julia 183 / 12

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

		State of Maryland	Certificate of	Death	Reg. No.9 9	05219
Physician	Decedent's Name (First, Middle, Las Ida				Date of Death Month Day	Year 3. Time of Death
/Medical Examiner	4a Facility Name (If not institution, give	Berkman street and number)		4b. City, Town, or Location	b. 22, 199 on of Death 4c. County	
Examiner	Crofton Conv.	Center		Crofton	Anne	Arunde1
Funeral Director	06201-6613	7. Age (In yrs. last	hirthday) If Under 1 Year Months Days	Hours Min. (Date of Birth Month, Day, Year) an.6,1903	Birthplaca (State or Foreign Country) New York
p & u	Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Location			10d. Inside City Limits
Marylan Filed.et	MD Prince	George Bow	ie			1 ☐ Yes 2 ☐ No
th with the Maryland 23e or 28e-f show ust be notified at rel Director	10e. Street and Number 12824 Holiday	Lane	10f. Zip Code 207	15	10g. Citizen of W	
Her des Hers mark	11. Marital Status 1 Never Married 2 Married 3X Widowed 4 Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1	13. Was Decedent of If Yes, specify Cub	tispanic Origin? (Specify an, Mexican, Puerto Rica Specify:		- American Indien, k, White, etc. White
Maryland 21215-0020 d 2 should be filed within 72 hours at the and Mental Hygiene. The marked other than "natural", or traumatic event, the Medical Exam. To Be Completed by F	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 1 2		6a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire Office Man	during most of working d)	16b. Kind of Bu	
be filed d other event.	17. Father's Name (First, Middle, Last)	2	OTTICE Mun		rst, Middle, Maiden Sumami	
ylan Wentsi mked o artic ev	Jacob Kriegel			Dora Ag	ins	Lie Stell
Age 2 sho	19a. Informant's Name/Relationship (7		19b. Mailing Address (Street		The second secon	
	Dale Bonnie Ge 20a. Method of Disposition		1/10 T1pt a of Disposition (Name of		Crofton, N	1D ZIII4 City or Town, State
Baltimore, semit. Pages 1 ac Separtment of Hea mportant: if Item: iny Injury or other ince.	1 DeBurial 2 Cremetion 3 Di 4 Donation 5 Other (Specify	Removel from State Knes	seth Israel	Cem. 2/		
Department of the partment of	21. Signature of Funeral Service Licens	And 1	Hardesty 12 Ridge		Home, P.A.	MD 21401
Physician	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ne cause on each line.	Do not enter the mode of dyi	ng, such es cerdiac or res	spiratory errest,	Approximate Interval Between Onset and Deeth
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)		tus tutic s a consequence of):	Colon G	an (er	Lyear
cate be executed physician end in the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as	a consequence of):			
	that initiated events resulting in death) Last	Due to (or as	a consequence of):			
B. Geath	Part II. Other significant conditions co	ntributing to death but not resultin	g in the underlying ceuse gi	ven in Part I.	23b. Did tobacco use con	tribute to the cause of death?
					1 Yes 22 No	3 Probably 4 Unknown
e been a z should					24a. Wes an eutopsy performed?	24b. Were autopsy findings evailable prior to completion of cause of death?
- F 44 0					1 ☐ Yes 2 No	1 ☐ Yes 2 ☐ No
Of Vital Physician: The Physician: This certificate ral director, page Co.: To Be Co.	25. Was case referred to medical examiner?	lospitat	Ort	26. Place of Deeth (C)		
T S S D	27. Manner of Death 1 Natural 5 Pending	1 Li Inpatient 2 Li ER	b. Time of thiury 28c. thiu Wo	41/2 Nursing Home	5 Residence 8 Other Describe how injury occurr	
Division o To the Hospital or Attending Ph within 24 hours eiter deeth. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)		28f.	Location (Street and Number City or Town, State)	er or Rural Route Number,
he Hospita in 24 hours he Funeral pletaty fille edical C	29a. Certifier (Check only a literal Example)	sician: To the best of my knowled ner: On the basis of examination and manner stated.	dge, death occurred at the ti and/or investigation, in my o	me, date and place, and opinion, death occurred a	due to the cause(s) and mai t the time, date and plece, e	nner as stated. and due to the cause(s)
To th To th Comp	29b. Signature and title of certifier	h. de N	29c. Licens			(Month, Dey, Year)
is eth	30. Name and address of parady who o	ompleted ceuse of death (Item 23	1000	22028	Lta Co.	2-99 te Crothen My
State Registrar	31. Date filed (Month, Day, Year) FEB 2 3 1999	32. Registrar's Signature	mo 1	00 (() 0	L'an Ch	re coursely



Please Type or Print In Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

LARRY	
BRUMMETT	

Physician * /Medical Examiner

Funeral

Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mantal Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, to Medical Experiment must be notified an once. Baltimore, Maryland 21215-0020 **Physician**

> /Medical Examiner

signed by the ettending physician end d be deteched for use as the buriel-trensit The law requires that the deeth certificete be execut been :

Physician/Medical Examiner

Completed by

Be

Medical Certification: To

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has it completely filled in by the funeral director, page 2.

			Ce	rtiticat	e or	Death	1		Reg. N	lo.		
Decedent's Name (First, Middle		y W. Br	ummett	;	- 11			2. Data of De Month FEBRUA)ay 19.1	Yaer 999	3. Time of Death 7:55P.M.
4a Facility Nema (If not institution	n, giva street and nu	mber)				4b. City, To	own, or l	ocation of Deat	- 1		y of Death	
HARBOR HOSPITA	L					BALT	IMOR	E			N/A	
5. Social Security Number 247 68 4964	6. Sax 1 X M 2□ F	7. Age (In yrs. 54	last birthday, Yrs.	Months	Days		Min.	8. Data of Bir (Month, Da June 1	av. Yea	1944	Cou	placa (Stata or Foreign ntry) rginia
Usual Rasidance of Dacedant												
10e. Stata 10b. County		10c. Cit	y, Town or L	ocation								10d. Insida City Limits
Maryland Anne	Arundel	Ba	ltimo	re								1 Yas 2X No
10e. Street and Number	W			10f. Zip	Code				10g. C	Citizen of	What Cou	intry?
4 - W. 9th Ave	enue				2122	25				U.S	5.	
11. Marital Status	12. Was Dac	edant Ever in U	,S. 13.	Was Dace	dant of I	Hispenic O	ngin? (S	pecity Yas or No	o-			can Indian,
1 Navar Marriad 2 Marr	Armed Fo	2X No						Rican, atc.)		Bla	ick, Whita	, atc.
3 ☐ Widowed 4 ☑ Divorced	If Yas, Gi Yaer or E	va Jetes:		1 Yas	2XINo	Specify				Specif	y: W	hite
15. Decedan (Spacify only highas	l's Education st grade completed)		16a. Dece (Give	dant's Usu kind of wo DO NOT u	al Occup ork dona	pation during mo	st of wor	king	16b.	Kind of B	lusinass/lr	ndustry
Elementary/Secondary (0-12)	Collega (1-4or 5+)	_	ippin					Ψa	to A	CCAS	s Flooring
12th 17. Fathar's Neme (First, Middle,	(act)		311.	rbbru	9 01		are Nan	na (First, Middla				5 TIOOTING
17. Falliai S Nellie (Filst, Middle,						TO. WOLL						
	John Bru	ımmett						lizabet				
19a. Informant's Name/Ralations	hip (Type, Print)							_				ip Coda) 37760
Kevin Brummett	son					ge St	reet					city, Tenn
20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 4 ☐ Donation 5 ☐ Other (S)		Stata	Placa of Disp camatary, cra 11top	metory or	other pla			Data 2/24/99			1	own, State ryland
21. Signatura of Funaral Servica	Pramu	ourth	-	2. Nama ai				Gonce lay Bal				
23a. Pent . Entar tha disaase or shock, or haert failura. List Immediata Causa (Final disaasa or condition rasulting in death)	complications that only one causa on e	causad tha daal each lina.	lesson and an					or respiratory of		asl	2	Approximete Intarval Between Onsat and Daath
Sequantially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disaasa or Injury	b		or as a conse									
that initiated events rasulting in daath) Last	d	Due to (c	r as a conse	quanca of):								
											1	
Part II. Other eignificant condition	ns contributing to d	eath but not res	ulting In the	undarlying	causa gi	ivan in Part	1.	23b. Did	tobac	co use co	ontribute	to the cause of death
A + .1.	M. 011							10	Yes	2□ No	3 □ Pro	obably AUnk

25. V

te to the cause of death? Unknown Probably

24a. Was an autopsy

24b. Ware eutopsy findings availabla prior to completion of cause of daeth?

2 No

Yas 2□ No

las casa refarrad to medical				26. Placa of De	eath (C	check only ona)	
xaminar? XYas 2□ No	Hospital:	2X ER/Outpatient	3□ DOA	Other: 4 Nursing	Homa	5 Rasidanca	6 □Other (Specify)
enner of Deeth	28a. Data of Injury	28b. Time of	28c. I	njury at	280	I. Dascribe how Inj	ury occurred

27. N Natural Accident 5 Panding invastigation 6 Could not be

3 Suicide

29b. Sig

4 T Homicida

(Month, Dey Yaar) 28e. Place of Injury - At homa, farm, straat, fectory, office building, atc. (Spacify)

Work? 2 No 1 ☐ Yas

28f. Location (Street end Number or Rural Routa Number, City or Town, Steta)

1 Certifying Physician: To the best of my knowledge, daeth occurred et the time, date end plece, and due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete and plece, end due to the cause(s) and manner stated.

29d. Data signed (Month, Day, Year)

O.C.M.E.

FEBRUARY 20, 1999

30 N

and eddrass of person, who completed cause of daath (Itam 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

31. Data filed (Month, Day, Year)

FEB 2 3 1999

32, Ragistrar's Signatura

DHMH 16 Rev 6/95

State

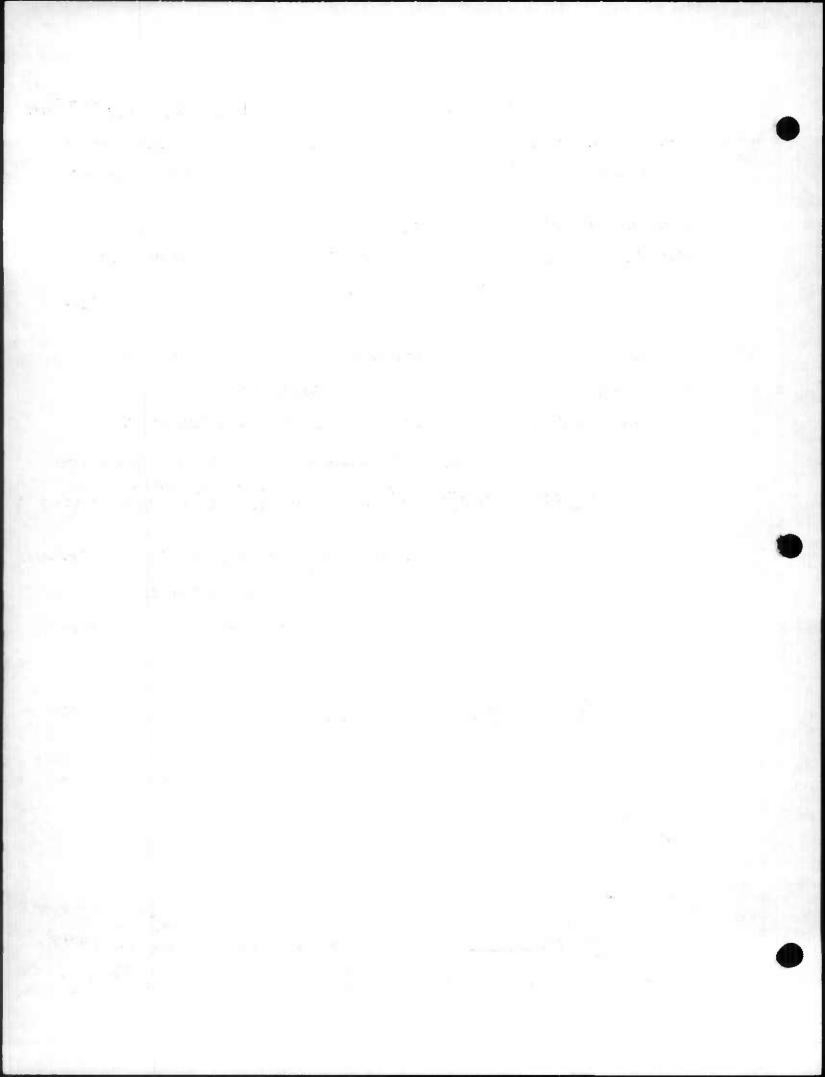
Registrar

the all the control and the Detector planting and the con-

THE RELIEF SHOP IN VIEW AND A MANAGEMENT

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	ion	1. Decedent's Name (First, Middle, Las	st)				2. Date of Dea		3. Time of Deat
Physic /Medi			uđe Elizab	eth Baug	her		Feb		99445A
Exami		4e. Fecility Name (If not institution, give	street and number)			4b. City, Town, or Lo	ocation of Death	4c. County of	Death
		Mariner Nursing H	ome			Laurel		Prince	e Georges
Funeral Director		217-07-8004	ex	82 Yrs	Months Days		8. Date of Birt (Month, Day Feb 6,	y, Year) 9 1917 N	Birthplece (State or Ford Country) Maryland
show	L	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Lin
Sa-f	Director	Maryland Howard	đ	Jessu	р				1 ☐ Yes 2€
or 2	Oire	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?
23a		8308 Firewood Cou	rt		20794			United	States
*naturel", or items 23a or 28a-f show	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Vidowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	Ever in U,S.	13. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 🛣 No		ecify Yes or No- Rican, etc.)	14. Race - Black, Specify:	Americen Indian, White, etc. White
and in	Pe	15. Decedent's Ed	ucetion	16a. De	ecedent's Usual Occu	pation		16b. Kind of Busin	ness/Industry
than the Me	Completed	(Specify only highest gra Elementary/Secondary (0-12) 12	de completed) College (1-4or 5	+)	Rive kind of work done fe. DO NOT use retire memaker	during most of workingd)	ing	Own Hon	
		17. Father's Name (First, Middle, Last)				18. Mother's Name	First, Middle,		
e d	To Be	Charles Lembach				Carrie Po			
h and Men 7 is marke traumatic	1	19a. Informant's Name/Relationship (1	Type, Print)	19b M	lailing Address (Stree			r. City or Town Ste	ate Zin Code)
h a		Karen Shupe/Daugh			8 Firewood				
DE E		20a. Method of Disposition		20h Piace of Di	isposition (Name of	T	Date Date	20c. Location - Clt	
0 = 5		1 Burial 2 □ Cremation 3 □		cemetery,	crematory or other pla				
ortant: ortant: injury		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		St. John	n's Cemete 22. Name and Addre	ery 2	-25-99	Ellicott	City, MD
Departme Importan any injur		23a. Part1. Enter the disease, or compshock, or heart failure. List only	Pino-to	inte !	Harry H. W 4112 Old C	ltzke's Fa Columbia P	ike Ell	icott Cit	ome, Inc. Ty, MD 2104 Approximate Interval Between
nysician Medicai kaminer	Examiner	Immediate Cause (Final disease or condition resulting in death)	өb.	Due to (or as e con	orovn psequence of): Dishel	ry su	tey"	bease	Year
and I-trar	хаг	Sequentially list conditions, if any, leading to immediate		Due to (or as e con	sequence of):				
icien		Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	C		Hyl	serker	sion		Yeons
ing physicien and a es tha bural-transit	an/Medical	that initiated events resulting in death) Last	d	Due to (or as a con	sequence of): U				
tand or us		Part II. Other algnificant conditions co	entributing to death bu	t not resulting in th	e underlying cause gi	ven in Part I.	23b. Dld t	obacco use contri	bute to the causa of de
ha attandin ned for usa	sici						400	/es 2□ No 3	
by tha	by Physician/N	Deul, L	us ula	ni, C	ivem (7	101		Probably Unk
is been signed by tha 2 should be datached	by	Demb, L	us ulc	n, C	jem (°	7	24a. Was	an autopsy 2 med?	24b. Were autopsy findin available prior to completion of cause of deeth?
ete has been signed by tha paga 2 should be datached	by	Demb, L	ns ula	n, C	jem (°	>	24a. Was	med?	24b. Were autopsy findin available prior to completion of cause
ete has been signed by tha paga 2 should be datached	Completed by	25. Was cese referred to medical		n, C	ivem (°	26. Plece of Deeth	24a. Was a period	med?	24b. Were autopsy findi available prior to completion of caus of deeth?
this cartificete has been signed by tha ral director, paga 2 should be datached	To Be Completed by	25. Was cese referred to medical examiner? 1 Yes 2 Coso 27. Manner of Death	Hospital: 1 ☐ Inpatier 28a. Date of Injur (Month, Day	nt 2□ ER/Outpa	stient 3 DOA Ott	26. Piece of Deeth	24a. Was a performance of Check only on the control of the control	med?	24b. Were autopsy findir available prior to completion of cause of deeth?
ifier daath. Diractor: After this cartificete has been signed by tha in by tha funaral director, paga 2 should be datached	Be Completed by	25. Was cese referred to medical examiner? 1 Yes 2 2 500 27. Manner of Death	Hospital: 1 ☐ Inpatier 28a. Date of Injur (Month, Day	ot 2 ER/Outpa	stient 3 DOA Ott	26. Plece of Deeth her: Nursing Hor ry at rk? I Yes 2 \(\) No	24a. Was a performance of the pe	res 2 Ao	24b. Were autopsy findir available prior to completion of cause of deeth?
rifer daath. Diractor: After this cartificete has been signed by tha in by tha funaral director, paga 2 should be datached	edical Certification: To Be Completed by	25. Was cese referred to medical examiner? 1 Yes 2 Too 27. Manner of Death Thatural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier 1 Certifying Physics	Hospital: 1 Inpatier 28a. Date of Injur (Month, Day) 28e. Place of Injur building, etc	nt 2□ ER/Outpa y Year) 28b. Tim Injui ry - At home, farm, (Specify) I my knowledge, de exemination end/o	itient 3 DOA Otl	26. Plece of Deether: Nursing Horizon Art (1988) Ty at (1988) Ty es 2 No	24a. Was a performance of the pe	res 2 Ano res) ence 6 Other (ow injury occurred treet and Number of m, State) eause(s) and manner	24b. Were autopsy findin available prior to completion of cause of deeth? 1 Yes (Specify) or Rural Route Number, er as stated.
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 8:40 AM Nellie Buettner Feb. 21,1999 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore If Undar 24 Hrs. 8. Do Hours Min. (A Mariner of Overlea Nursing Home If Under 1 Yaar Months Days 7. Age (In yrs. last birthday) 5. Social Sacurity Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 2X F Dec.1,1923 West Va. Director 217-22-3744 75 Usual Residence of Decedent with the Marylenc 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f shot traumstic event, the Medical Examinar must be notified as 1 ☐ Yes 2 ☐ No Director Md. Baltimore Essex 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 812 Lannertown Rd. 21220 U.S.A. Funeral daath 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - American Indien, 11. Marital Status Bleck, White, etc. pemit. Pegas 1 and 2 should be filed within 72 hours after a Department of Heelth and Mantal Hygiena. Important: If Itam 27 is marked other than "natural", or theil any Injury or other traumetic event, the Medical Examina 1 ☐ Yes 2 ☐ No If Yes, Give X 1 Naver Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Homemaker

18. Mother's Name (First, Middle, Maiden Sumame) 7th 17. Father's Nama (First, Middle, Last) Own-Home James Huffman Leola Cooper 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 812 Lannertown Rd., Essex, Md. 21220 on (Name of Dete 20c. Location - City or Town, Stata Patricia Hammonds / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OakLawn Cemetery 2-24,99 Balto., Md. 21. Signatura of Funaral Service Licansee 22. Name and Address of Facility Moran-Ashton-Dabrowski Funeral Home, Inc 3000 E. Baltimore St., Balto.Md. 21224 23a. Pert1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. **Physician** CARCINONA OF LUNG /Medicai Immediate Cause (Final MONTH disease or condition resulting in deeth) Examiner Due to (or es a consequence of): Examiner that the death cartificete be axecuted physician and s the burief-trens Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceusa (Diseese or Injury that initiated events resulting in death) Lest Due to (or as e consequenca of): Physician/Medicai Due to (or es a consequenca of): 88 usa Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by t Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of deeth? TERY DIS, Completed 24e. Was en eutopsy performed? 1 Tyes 2 No 1 Yes 2 No funaral director, 25. Wes case referred to medical Be 26. Place of Death (Check only one) examiner? 1□ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28c. Injury et Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred or Attending P after death. After 1 Naturel 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, straet, fectory, offica building, etc. (Specify) 4 Homicide Hospital 24 hours a 24 hours Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune complately fi (Check only 29d. Date signéd (Month, Day, Year) 29b. Signeture and title of el 29c. Licensa number · RIVERA · RAMIREZ

ROAD,

32. Registrar's Signeture

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) HARFORD

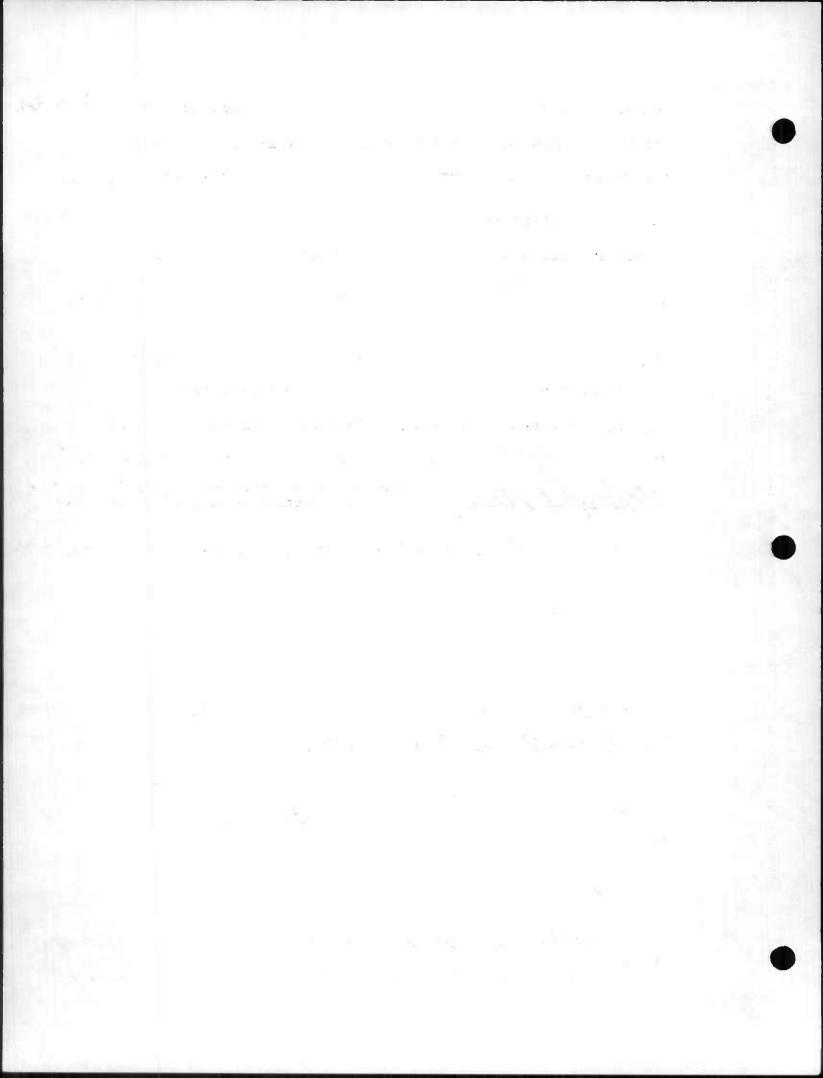
31. Date filed (Month, Day, Year)

FEB 2

DHMH 16 Rev 6/95

State

Registrar



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Deeth 1. Decedent's Nama (First, Middle, Last) Month Day February 19 1949 1:30 AM Albert Andrew Sr. Bauer 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Nama (If not institution, give street end number) Bultimore Sinai Baltimorp Hos 8. Date of Birth (Month, Dey, Year) Aug. 24 1940 If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) Deys 1 M 2□ F 214-38-3838 Yrs. 58 MAryland Usual Residence of Decedant 10a State 10b. County 10c. City, Town or Location 10d. toside City Limits Md. Baltimore Essex 1 Yes X No 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 355 Stillwater Road 21221 USA 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indien 11 Maritai Status Black, White, etc. Yes 2 No If Yes, Give 1 Never Merried 2 Married 1 ☐ Yes 20 No Specify: White it Yes, Give Year or Dates: 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elemantary/Secondary (0-12) Collega (1-4or 5+) Plumbing Plumber 8th 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumeme) Edward Bauer Alverta Mol1 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Streat and Numbar or Rurel Route Number, City or Town, Stete, Zip Code) 916 Foxwood LAne 21221 Jeffery Bauer / son Baltimore Md. 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition N☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 2/23/99 Holly Hill Cemetery Baltimore Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Neme and Address of Fecility Connelly Funeral Home of Essex 300 MAce Ave. Baltimore Md. 21221 intervel Between Onset and Death Immediate Causa (Final 1 veek disease or condition rasulting in death) Gangrene Sequentielly list conditions, if any, leading to immediate ceusa. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): 23h. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Coronary Artery Disease, status post CADG 24e. Wes an autopsy performed? 24b. Were eutopsy findings aveilable prior to Perhipheral Vascular Disease, Cardiomyopathy completion of cause of death? 25. Was cesa referred to medicel axaminar? 2 NO 1 ☐ Yes 2 ☑ No Ana saria 26. Placa of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Menne of Death 28h Time of 28c. Injury at Work? 5 Pending Investigation

Records,

Physician

/Medical

Examiner

Director

Funeral

Completed

Funeral

Director

tran "natural", or items 23s or

permit. Peges 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examina any injury or other traumatic event, the Medical Examina any injury or other traumatic event.

Physician /Medical

Examiner

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After this

Director: /

A 24 hours the Funeral Dire

within 2

Physician/Medical Examiner

by

Completed

Be

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Certification:

edical

2 Accident

3 ☐ Suicide

4 Homicida

(Check only one)

31. Date filed (Month, Day, Year)

FEB23

Baltimore, Maryland 21215-0020

death with the Maryland

The law requires that the death certificate be executed Division of Vital or Attending

Registra

State

2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred at the time, data end place, and due to the cause(s) and menner stated. 29b. Signeture end title of certified

6 Could not be datarmined

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the causa(s) end menner as stated.

29d. Date signed (Month, Dey, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

RES-000

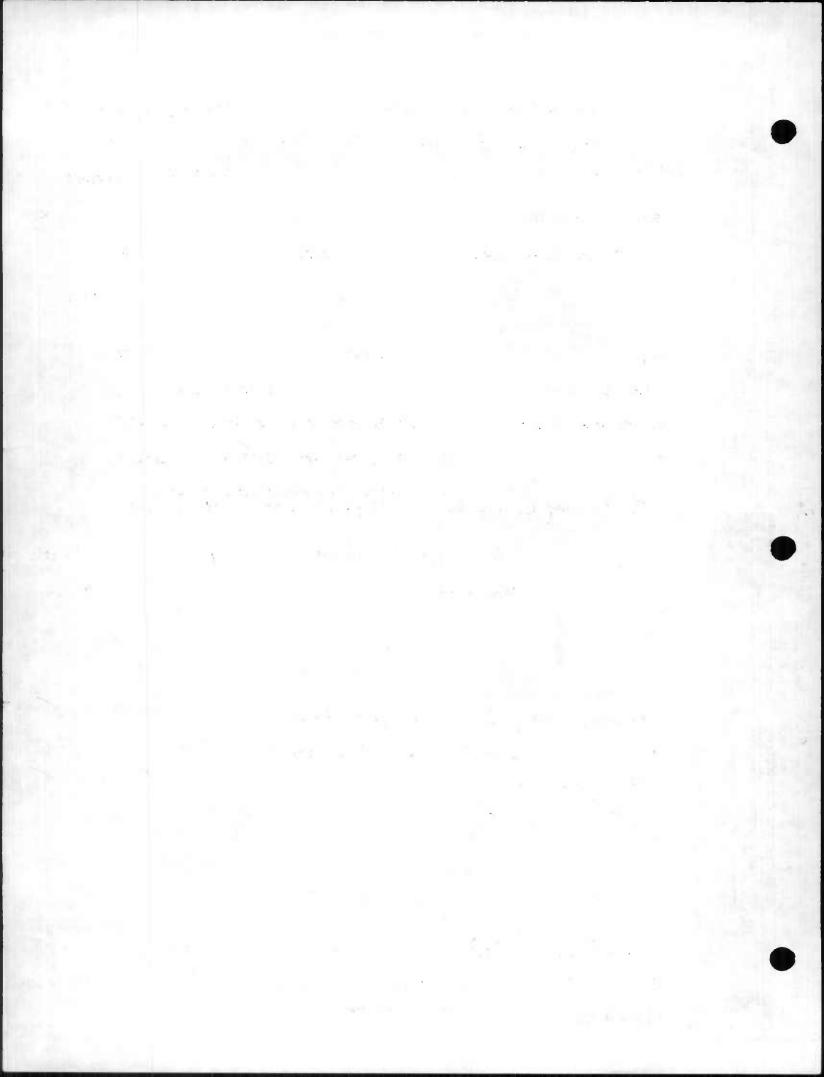
1 Yes 2 No

30. Name end address of person who completed cause of death (Itam 23a) (Type, Print) Tandez

W. Belvedere Ave. Bitto. MD 21215

32. Registrar's Sig

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day BUECKER 04:20 AM HELEN FEBRUARY 19 1999 /Medical 4a. Fecility Neme (If not institution, give street and number)

TOHNS HOPKINS BAYVI EW MEDICAL 4b. City, Town, or Location of Death 4c. County of Death Examiner CENTER BALTIMORE n/a 7. Age (In yrs. last birthday) If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sept. 14 1928 5. Sociel Security Number Birthplace (State or Foreign Country) **Funeral** 1 M 25€F 213-26-2709 Director 70 PA. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours effer death with the Meryle Department of Heelih end Mental Hygiene. Important: if item 27 is merked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified an once. Md Baltimore MIddle River Director 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen ot What Country? 3412 Honeysuckle Lane 21220 USA Funeral 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 Yes 2 No Specify: þ Specify: Usa 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind ot Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Computer 12th Operator Library 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Katherine 2 Philp J. Keck 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Janet Burkett / daughter 2610 Sparrows Point Road Baltimore Md. 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurlal 2 ☐ Cremetion 3 ☐ Removal from State Moreland Memorial 2/22/99 4 □ Donation 5 □ Other (Specify) Baltimore Md. 21. Signature of Funeral Service License 22. Name and Address of Facility Connelly Funeral Home of Essex 6nm 300 Mace AVe. Baltimore Md. 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. Let only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) INFERIOR MYOCARDIAL INFARCTION 48 HOURS Due to (or as a consequence of) Examiner HOURS 48 CEREBROVASCULAR ACCIDENT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es a consequence of): Physician/Medical Due to (or as a consequence of) Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Was en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 ☐ Yes 2 X No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 26a. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending Investigation 1 Netural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

or Attanding Physician: The law requires that the death certificate be executed Box 68760. ettending physician for use es the burie P.O. signed by t Division of Vital Records, certificate this After death.

Examine

with the Merylend

Baltimore, Maryland 21215-0020

28a-f show

after death filled in by the To the Hospital of within 24 hours at To the Funerat D completely filled

> State Registrar

EAOBOILESUNG MD RESIDENT

PHYSICIAN

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) end menner es stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated. 29c. License number

97008

29d. Date signed (Month, Dey, Yeer) FEBRUARY 19, 1999

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)
PATIENCE AGBORBESONG MD
PASTERN AVENUE BAL BALTIMORE, MARYLAND 21224 31. Date filed (Month, Day, Year)

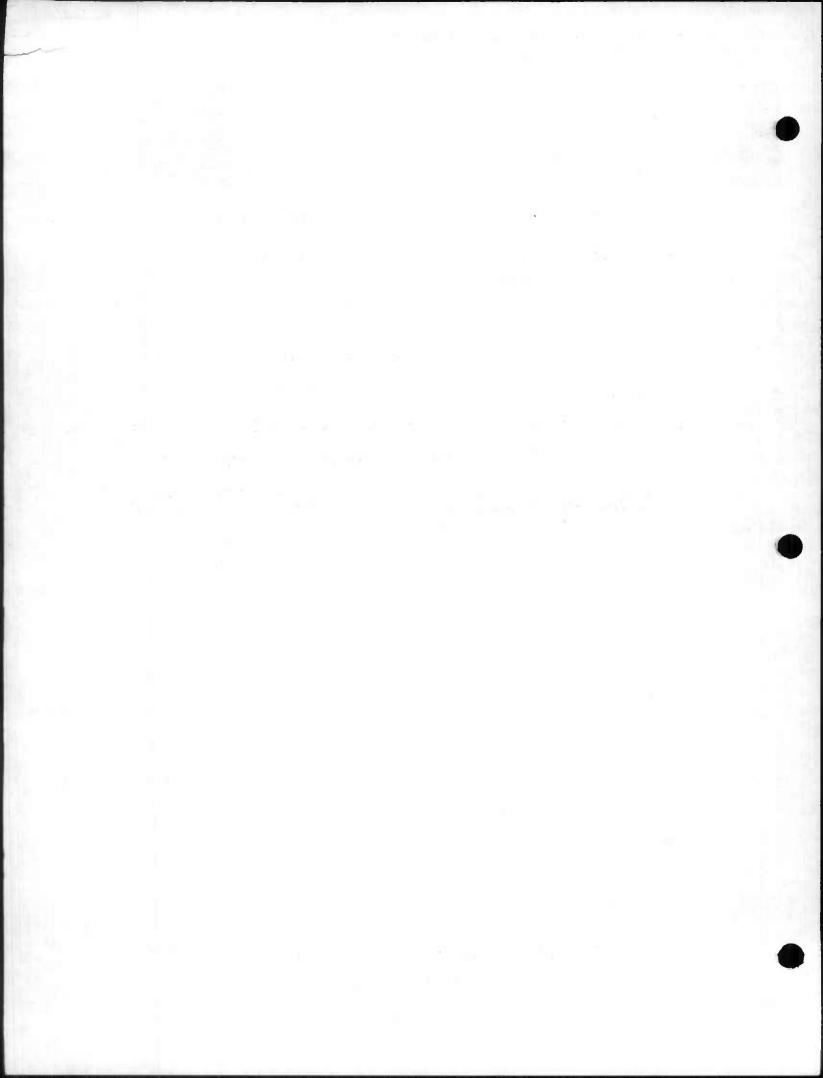
FEB 23 1999

4 Homicide

29b. Signature and title of certifier

29a. Certifier (Check only one)

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death **Physician** Month Dey 16, 1999 6:05 AM February **EDNA** RUTH CHRISTIAN /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Stella Maris Hospice if Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Yaar) If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (Steta or Foraign Country) **Funeral** 1 □ M 2 🕱 F Days Yrs. Director 65 053-28-6146 NY Usual Residence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. insida City Limits 1 Yas 2 No Director N/A Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? USA 2525 Guilford Ave. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ঐ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indien, Black, Whita, atc. 1 Nevar Married 2 ☐ Married 1 ☐ Yas 2 ☐ No Specify: þ Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Dacedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highast grade completed) Department of Health and Mental Hygiena. Important: If Item 27 is marked other then any Injury or other treumatic event, the Mesons. Elamentary/Secondary (0-12) Collaga (1-4or 5+) 12 Secretary Manufacturing 17. Fether's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) P Rosella. Loucks Hudson George 19a. informant's Name/Ralationship (Typa, Pnnt) 19b. Mailing Addrass (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) Mr. Ronald Christian/son 2525 Guilford Ave. Baltimore, Md. 21218 20b. Piace of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 SBurial 2 Cramation 3 Ramovel from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Ballston Spa Cemetery 2/19/99 Ballston Spa, 22. Nama and Addrass of Facility
Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 Entar tha disaase, or complications that caused the daath. Do not antar tha moda of dying, such es cardiac or raspiratory arrast, or haart failura. List only ona causa on aech lina. Approximata Intarvai Batw Onset end Death Physician /Medicai Immadiata Causa (Finai Renal Cancer disaasa or condition rasulting in daath) Examiner Dua to (or as a consequance of): Physician/Medical Examiner Sequantially list conditions, if eny, laading to immediata causa. Entar Undarlying Causa (Disaasa or injury thet Initiated avants rasulting in daath) Last Dua to (or as a consaguance of): Dua to (or es a consequança of): Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 2 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No Be 25. Was casa rafarrad to medical 26. Piaca of Death (Check only ona) exeminar? Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA Othar: 4 Nursing Homa 5 Residence 6 MOthar (Specify) Hospice Certification: To 1 ☐ Yas 2 No 28a. Data of Injury (Month, Dey Year) 27. Mannar of Death 28d. Describe how Injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural 5 Panding 1 Yas 2 No invastigation 2 Accidant 6 Could not be 3 ☐ Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. Medical 29a. Cartifier 29b. Signatura and titla of certifiar 29c. Licensa number 29d. Data signad (Month, Dey, Year) D43725 30. Nama and addrass of person who complated ceusa of death (itam 23a) (Type, Print) Dr. Taria Mahmood, 2300 Dul 2300 Dulaney Valley Road, Timonium, MD

Registrar

State

28a-f show must be notified at

items 23a

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physician and is the burlat gansit

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s certificate has t director, page 2 s

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s after death.
I Director: After to in by the funera

within 24 hours aft To the Funeral Di completely filled in

To the

director.

The law requires that the death certificate be executed

Edna

of Vital

Division

with the

Maryland 21215-0020

February 16,

Baltimore,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 05227

			Certi	ificate of	Death		Reg. No.	UJ	661
	1. Decedent's Name (First, Middle, L	ast)			1500	2. Date of Der Month		Year	3. Time of Death
Physician /Medical	James Chilis					Februa			1:35 P.M.
Examiner	4e Facility Name (If not institution, gi	ve street end number)			4b. City, Town, or	Location of Death	4c. County		2000 2000
Funeral Director	214-30-6133).o. looi billioo)/	If Under 1 Year Months Days			Balti v, Yeer) 1 1918		ece (State or Foreign ny) ECE
pue &	Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Loca	ition				10	d. Insida City Limits
Aaryli Feho	MD. Baltim		ockeysvil					3	1 ☐ Yes 2 No
with the hard or 28a-	10e. Sfreet end Number 12 Hillsyde Ct.			10f. Zip Code 2103	0	10g. Citizen of What Country? USA			
Designation of the proof of the	11. Marital Status 1 Never Married 2 Married 312 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	lf Y	as Decedent of res, specify Cul	Hispanic Origin? (Span, Mexican, Puel	Specify Yes or No- rto Rican, etc.)	Blac	e - America k, White, e	etc.
72 ho	15. Decedent's E (Specify only highest g	ducation	16e. Deceder	nt's Usual Occu	pation	ntkina	16b. Kind of Bu	siness/Ind	ustry
filed within 72 ho Hygiena. ther than "neture out, the Medical	Elamentary/Secondary (0-12)	College (1-4or 5+)		e. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT usa ratired) e1f Employed			Restaur	staurant	
Paring Co	17. Father's Name (First, Middle, Las	<i>t</i>)		1 2		me (First, Middle,	Maidan Sumem	(a)	
2 should be filed and Mental Hygi is marked other aumatic event, To Be Cc		iberdis				Fournard		,	
should ind Men	19a. Informant's Name/Ralationship	(Type, Print)	19b. Malling	Addrass (Stree	at and Number or R	lural Route Numbe	er, City or Town,	Stete, Zip	Code)
C, Ma 1 and 2 Health a am 27 is ther trai	Ms. Denise Chili	s/Daughter	12 Hi	llsyde	Ct. Cock	eysville	, MD. 21	030	
of Hear	20e. Method of Disposition		b. Place of Disposit	tion (Neme of	ece)	Date	20c. Location -	City or Tov	wn, Stata
Pages nent of l	1 ☐ Burial 2 ☐ Cremefion 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		reek Orth			2-22-99	Woodlaw	m, MI	o.
Description of and 2: Department of and 2: Department of Health an important: if lem 27 is any Injury or other trau	21. Signature of Funeral Servica Lica		22. 1	Name and Addi Ruck T	ress of Facility OWSON Fu		me, Inc.		
	23a. Part1. Enter the disease, of cor shock, or heart failure. List only	13			rk Rd. To				Approximata
certificate be associted defined by season and the burial fransit as the burial fransit and	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Causa (Disaase or Injury that initiated events resulting in death) Last	c	to (or as a conseque						
for for for	Part II. Other significant conditions	dcontributing to death but no	t resulting in the und	lerlying cause g	iven In Part I.	23b. Dld	tobacco use co	ntribute to	the cause of death?
						10	Yes 2XXIo	3 Prob	ably 4 Unknow
The law requires that the de sate has been signed by the page 2 should be detached Completed by Physic						24a. Was	an autopsy med?	eva	re autopsy findings illabla prior to appletion of cause daath?
						1聚	res 2□No	15	Yes 2□ No
certificata rector, pag	25. Was case raferred to medical examiner?				26. Place of De	ath (Check only o	na)		
Physician: This certificat	1 XYes 2 □ No	Hospital:	2 ER/Outpatient	3□ DOA O	ther: 4 Nursing	Home 5 ☐ Resid	denca 6 □Oth	er (Specify)
ng Pt tarth neral	27. Mannar of Daath 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Dey Yea	28b. Time of Injury	28c. Inj. W	ury at ork?	28d. Dascribe	now injury occur	red	
Attending in death. ector: Afta fune by the fune liffication	2 Accident Investigation	Nov. 6,19			Yes 2 No	Subject	t was be	eaten	
tal or Attending P is after death. al Director: After led in by the funer. Certification:	3 ☐ Sulcide 6 ☐ Could not datermine	28a. Placa of Injury - building, etc. (Si	pecify)			28f. Location (: City or To	Street end Numb vn, Stete) 45	er or Rure 05 Ur	Route Number, aderwood
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifica completely filled in by the funeral director, Medical Certification: To Be ((Check only 2 Medical Exa	hyalofan: To the best of my miner: On the basis of exa		occurred at the		e, and due to the		anner as sta	ated.
thin 2 the mple	29b. Signature and trie of cartifier	and manner stated.		29c Lines	nse number	T	29d. Date signe	d (Month I	Day Year)
F ¥ F Ø	Delan For	melhoe		250. Elder	O.C.M.	E. 1	February		
10	30. Name and address of person who	complated causa of death							
	MANYDOUTA	P. KOREL	Jul 11:	1 Penn	Street, I	Baltimore	e, Maryl	and 2	1201
State	31. Date filed (Month, Dey, Yaer)	999 32. Redistrar's S	Signatura	Span	de)				

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death 2. Date of Death Criswell, Jr. George Grason

3. Time of Death 1. Decedent'a Name (First, Middla, Last) Day 1999 Month Feb. Physician 23, 6 a.m. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 217 Highmeadow Rd. Reisterstown Baltimore If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 24,1919 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 213-05-5041 107M 20 F 79 Yes Maryland Director Usuat Residence of Decedent with the Maryland 10a State 10b County 10c. City. Town or Location 10d. toslde City Limits r than "natural", or items 23s or 28s-f show the Hedical Examinar must be notified at 1 Yes 27 No Director Md. Baltimore Reisterstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21136 217 Highmeadow Rd. U.S.A. death v Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 (Ayes 2 □ No H Yes, Give Yeer or Detes: WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. I important: If Item 27 is marked other than "natural", or her any injury or other traumatic even. 1 Never Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: h White 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Western Electric 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumama) Be George G. Criswell Ella Carrick 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Helen Criswell 217 Highmeadow Rd., Reisterstown, Md. 21136 20b. Place of Disposition (Name of cematary, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 \$\mathbb{M}\$ Burial 2 □ Cremation 3 □ Removal from State Evergreen Mem. Gardens Feb. 25, 1999 Finksburg, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licega 22. Name and Address of Facility 21117 Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Examiner burisl-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last pue Due to (or as a consequence of): P.O. Box 68760, attending physician for use es the buris Physician/Medical Due to (or es e consequence of): USB 08 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be deteched 3 Probably 4 Unknown þ 24b. Were autopsy findinga available prior to completion of cause of death? 24a. Was en autopsy performed? Completed PANCHTOPKNZA has 2 No 1 Yes certificata To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, Be 25. Was cese referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 Yes 25 No Medical Certification: To 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Naturel 2 Accident 5 Pending Investigation 1 Yes 2 No 6 Could not be 3 ☐ Suicide Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

Records, Division of Vital

10 **DHMH 16 Rev 6/95**

State Registrar

31. Dete filed (Month, Day, Year) FEB

29b. Signeture and title of pertifier

30. Name and address of person who compl

29a. Certifier

32. Registrar's Signature 21

ed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es steted.

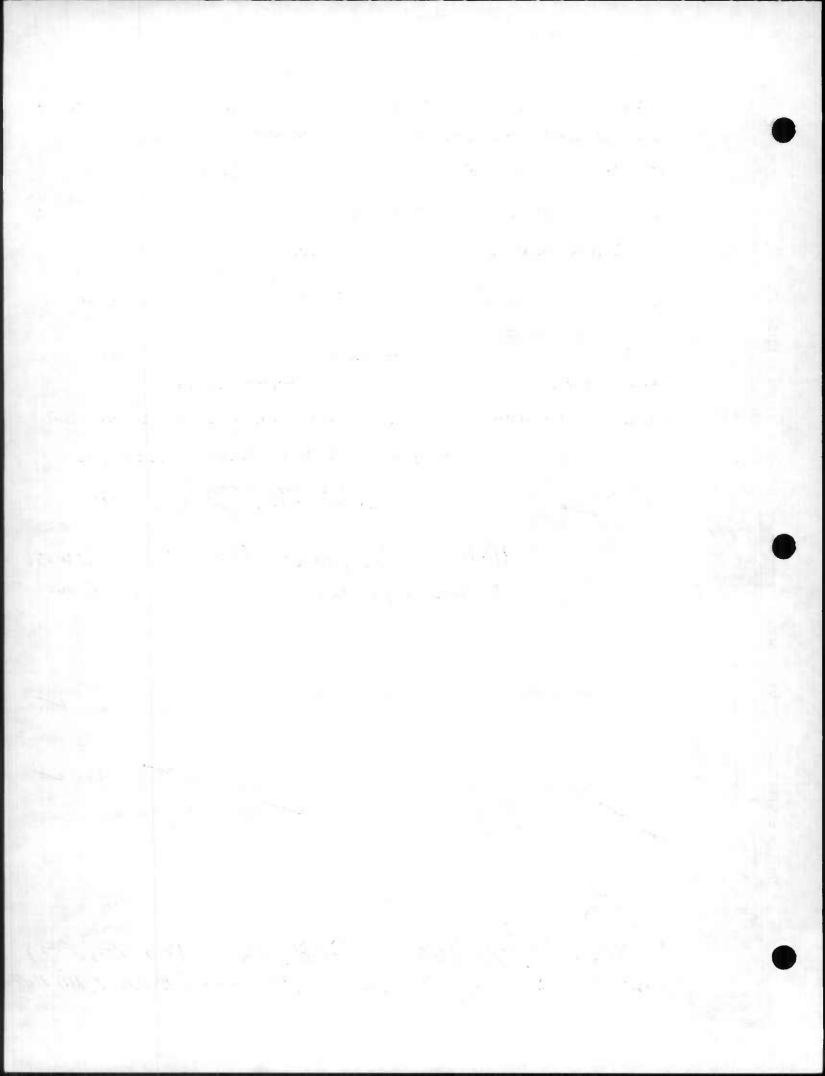
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Dey, Year)

Please Type or Print In Black indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

Dhamb	1.	Decedent's Name (First, Middle, L					2. Dete of De Month		3. Time of D		
Physician /Medical		Margaret	Α.	Cru			Feb.	21,1999	8:45		
Examiner	48	Manor Care Nurs		ssville		4b. City, Town, or L Rosedal	е	Balti			
Funeral Director		220-07-6311	Sex 1□M 2X F 7. Age (In yrs. last birtl Y	day) If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 5-15-	th ay, Year)	9. Birthplace (State or Country) MD		
f show	10	sual Residence of Decedent Da. State 10b. County Balt	imore	0c. City, Town	or Location per Falls				10d. Inside City		
3a or 28a-f s at be notified al Director	10	De. Street and Number	wood Rd.		10f. Zip Code	1156		10g. Citizen of Wh	net Country?		
tal Hygiene. d other than "natural", or items 23e or 28e-f show event, the Medical Examiner must be notified at Be Completed by Funeral Director		Merital Status □ Never Married 2	Armed Forces?	Yes 27 No s, Give 1 ☐ Yes 2 XNo			pecify Yes or No Rican, etc.)	14. Rece Black, Specify:	14. Rece - American Indian, Black, White, etc. Specify: White		
n natur		15. Decedent's 8 (Specify only highest g Elementary/Secondary (0-12)	5. Decedent's Education only highest grede completed) ary (0-12) College (1-4or 5+) O 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				sing	ng 16b. Kind of Business/Industry Own Home			
d other event, I Be Cc		7. Father's Neme (First, Middle, Las	•	18. Mother's Name				e (First, Middle, Meiden Sumeme)			
ind Mental Hygiene. I marked other than umatic event, the N To Be Comp		Owen C. McAtee					ret A.				
n 27 la me	19a. Informant's Name/Relationship (Type, Print) Winifred Kilian / sister 19b. Mailing Address (Street and Number or Rural F							Rosedale,	MD 21237		
Department of Health ar Important: If Item 27 Is any Injury or other trau once.	20	Da. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		cemetery	Disposition (Neme of coremetory or other pleam of an Memoria)	Park	Date 2-26-99	Flat Ro	ock, MI		
Department Important: If any Injury o once.	2	1. Signature of Funeral Signature Line	ensee	AT		ess of Facility n/Rosedalo saco Ave.			21237		
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is been signed by the attending 2 should be detached for use a pieted by Physician/M	-	art II. Other significant conditions	contributing to death but r	not resulting in	the underlying cause gi	ven in Part I.	1 🗆		1		
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ufer death. Nrector: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use artification: To Be Completed by Physician/M	25	5. Was cese referred to medicel examiner? 1	Hospitel: 1 Inpatient 28a. Date of Injury (Month, Day Y	2 □ ER/Out 'ear) 28b. T	patient 3□ DOA Ot me of 28c. Inju	26. Place of Dea her: → Nursing H ry at rk?] Yes 2 □ No	24a. Warperf	Yes 2 No s an eutopsy omed? Yes 2 No one) Idence 6 Other how Injury occurre	24b. Were autopsy fin available prior to completion of ce of death? 1 Yes 2 4 7		
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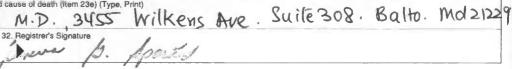
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Deeth CIFALA **Physician** FANNIE JOSEPHINE 10:56 AM Feb. 11 , 1999 4c. County of Deeth /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner ST. MARTINS HOME (LSOP) CATONSVILLE BALTIMORE | | Under | Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foreign **Funeral** 216-12-6670 Director 89 DEC 18,1909 MARYLAND Usual Residence of Decedent with the Maryland 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show 10d. Inside City Limits BALTIMORE CATONSVILLE 1 ☐ Yes 2 N No Director MARYLAND 10e. Street end Number 10f Zin Code 10g. Citizen of Whet Country? 601 MAIDEN CHOICE LANE - #9 21228 U.S.A. death Funeral 12. Wes Decedent Ever In U.S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Yeer or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: g WHITE 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) OWN HOME HOMEMAKER permit. Pagas 1 and 2 should be filed.
Department of Health end Mental Hygic
Important: If Item 27 Is marked other any Injury or other traumatic evant. 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be CONCETTA LASCOLA ANTONIO LIBERTO 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 601 MAIDEN CHOICE LANE #9 CATONSVILLE, MD 21228 FREDERICK G. CIFALA/ HUSBAND 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) BALTIMORE, MARYLAND NEW CATHEDERAL CEMETERY 2/13/99 21. Sign Dure of Funerel Service Licanses 22 Name and Address of Facilit HUBBARD FUNERAL HOME, INC. uprata K 4107 WILKENS AVENUE-BALTIMORE, MD 21229 thomas 23e. Pert . Enter the disease, or complications that ceused the death. Do not enter the mode of dylng, such as cerdiac or respiretory errest, show, or heart failure. List only one ceuse on each line. Approximete Intervel Between **Physician** /Medical Immediate Ceuse (Final 8 days BRAIN STEM disease or condition resulting in death) Examiner certificate be axecutad burial-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initialed events resulting in death) Lest pue Due to (or es e consequence of): Box 68760. Physician/Medical the Due to (or es e consequence of) P.O. 1 Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signad by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown NEW ONSET DIABETE MELLITUS WITH Records. HYPEROSMOLAR STATE. 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed RENAL FAILURE CHRONIC OBSTRUCTIVE LUNG DISEASE 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Wes cese referred to medicel examiner? Be 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 M Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) Medicai Certification: To 27. Menner of Death 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of Division 5 Pending Investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 - Homicide 156 Certifying Phyelclan: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examination end/or Investigetion, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end menner stated. 29e. Certifier 29b. Signature end title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number anal le-Ranfino

REP

31. Dete filed (Month, Dey, Year) State Registrar

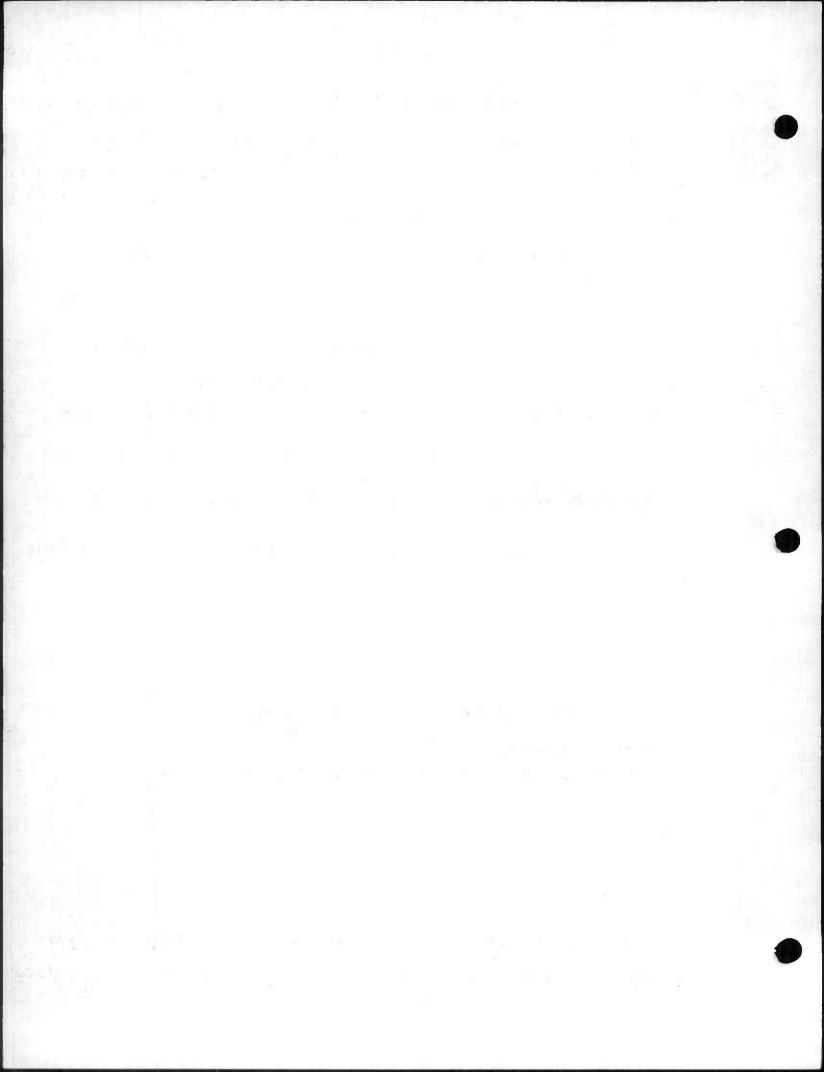
KOMAL



Feb., 11, 1999

30, Name end eddress of person who completed cause of death (item 23e) (Type, Print)

K. DANG



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dev Yeer **Physician** 6:05 -eros February 20 1999 DM /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deetly 4c. County of Deeth Examiner Good Samaritan Hospital Baltimore If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplece (Stete or Foreign Country) 8. Dete of Birth (Month, Dey, Year) Deys Months Hours 1X M 2□ F 213-05-6586 Yrs. 82 January 15, 1917 Maryland Usuel Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director Maryland Baltimore Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Wiltshire Road U.S.A. 21221 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritel Stetus Bleck. White, etc. 1 Yes 2 No
If Yes, Give
Yeer or Dates: WWII 1 Never Merried 20 Married 1 ☐ Yes 2 ☒ No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bus Company 6 Mechanic 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Frederick Canary Mamie Zippling 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e, Informent's Name/Reletionship (Type, Print) Emma E. Wiltshire Road, Baltimore, Maryland 21221 Canary 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Parial 2 ☐ Cremetion 3 ☐ Removel from State Oak Lawn Cemetery 2/24/99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221
nter the mode of dying, such as cardiac or respiratory errest, Approximate 23a. Pen1. Enter the disease, or complications that dised the death. Do not ente shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediete Ceuse (Finel diseese or condition resulting in death) Examiner Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contributa to the causa of death? Pert II. Other stanificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings aveileble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? 2 X No 1 Yes 1□Yes 2□ No 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred Certification: 5 Pending investigation Injury Nature! 1□ Yes 2□ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner es steted. edical 2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one)

end I-transit The law requires that the death certificate be executed physician ers the buriel-t P.O. Box 68760. ettending p signed by the e Records, peen is certificate hes t Division of Vital or Attanding Physician: this After this death. within 24 hours efter death To the Funeral Director: / completely filled in by the Hospital

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Hygiene.

marked other

permit. Pages 1 end 2 should be file Deportment of Heelth and Mentel Hy Important: if flem 27 is merked othn any injury or other traumatic event page.

Physician /Medical

Examiner

BSN

the Maryland

filed within 72 hours efter death with

Baltimore, Maryland 21215-0020

State

Dudek. 31. Dete filed (Month, Dey, Year)

29b. Signature and tiple of certifier



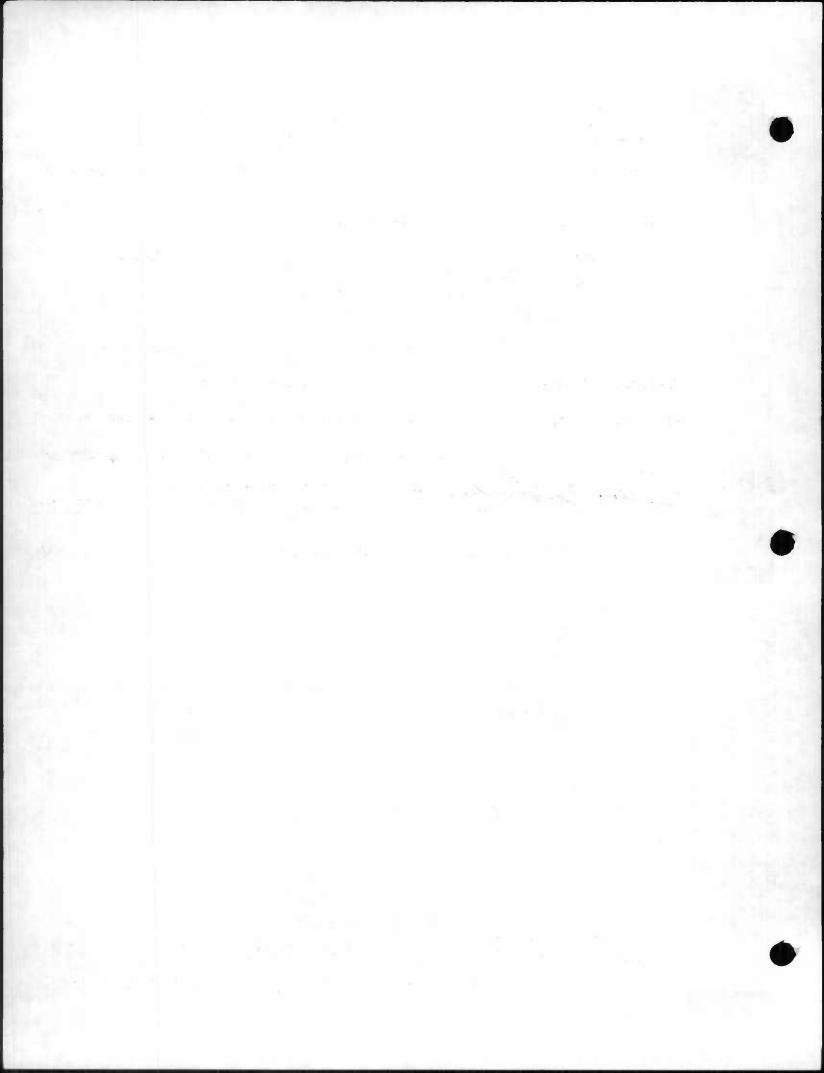
30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

Samari Gour tan

29c. License number

29d. Dete signed (Month, Dey, Year)

Registra 1999



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Year Virginia Catherine Curtis 11, 10:50 A.M. 1999 February 4a Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Mariner Health Rehabilitation Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□ M 21XF 84 Yrs. 219-30-4265 Jan. 19, 1915 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 🂢 ☐ No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 Shelly Road 21061 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Maritel Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) 8th College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Parks William Keefer 19a. fnformant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernest G. Curtis, Sr. (Husband) 103 Shelly Road Glen Burnie, Maryland 21061 20e. Method of Disposition (Name of cemetery, cremetory or other place) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State Glen Haven Memorial Park 2/15/99 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fyneral Service Licanspe 22. Name and Address of Facility Kevin E. Ecker McCully-Polyniak Funeral Home P.A. 237 F. Patapsco Avenue Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, Approximate Interval Between Onset and Deeth Immediate Cause (Final Accident months eremovos a diseese or condition resulting in deeth) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown teurion 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an eutopsy 1 Yes 2 No 1 ☐ Yes 2 No

Physician /Medical Examiner

Bud

certificate

be exacuted

Box 68760

P.O. I

Records,

Division of Vital

Physician

/Medical

Examiner

Funeral

Director

28a-f show

natural, or hams 23s or

flied within Hygiene. other than

permit. Pages 1 and 2 should be flied Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event,

altimore, Maryland 21215-0020

Directo

Funeral

Be

2

Physician/Medical by Completed Hospital or Attending Physician:
24 hours after death.
 Funeral Director: After this certifical letely filled in by the funeral director. Be edical Certification: To

signed by the eld be deteched f

To the Hosp within 24 ho To the Fune completely fi

State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year) FEB 23

25. Was case referred to medical

29b. Signeture end title of certifier

5 Pending investigation

6 Could not be determined

1 Yes 2 No

27. Manner of Deeth

2 Accident

4 Homicide

3 Suicide

29a. Certifier

1 MNatural

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3350 DR. OCHANEY

302 32. Registrer's Signature

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28e. Placa of fnjury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Year)

28c. Injury at Work?

29c. License number

D-40521

Wilkers

Baltimores

1 ☐ Yes 2 ☐ No

26. Placa of Death (Check only one)

Other: 4) Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how Injury occurred

Arome

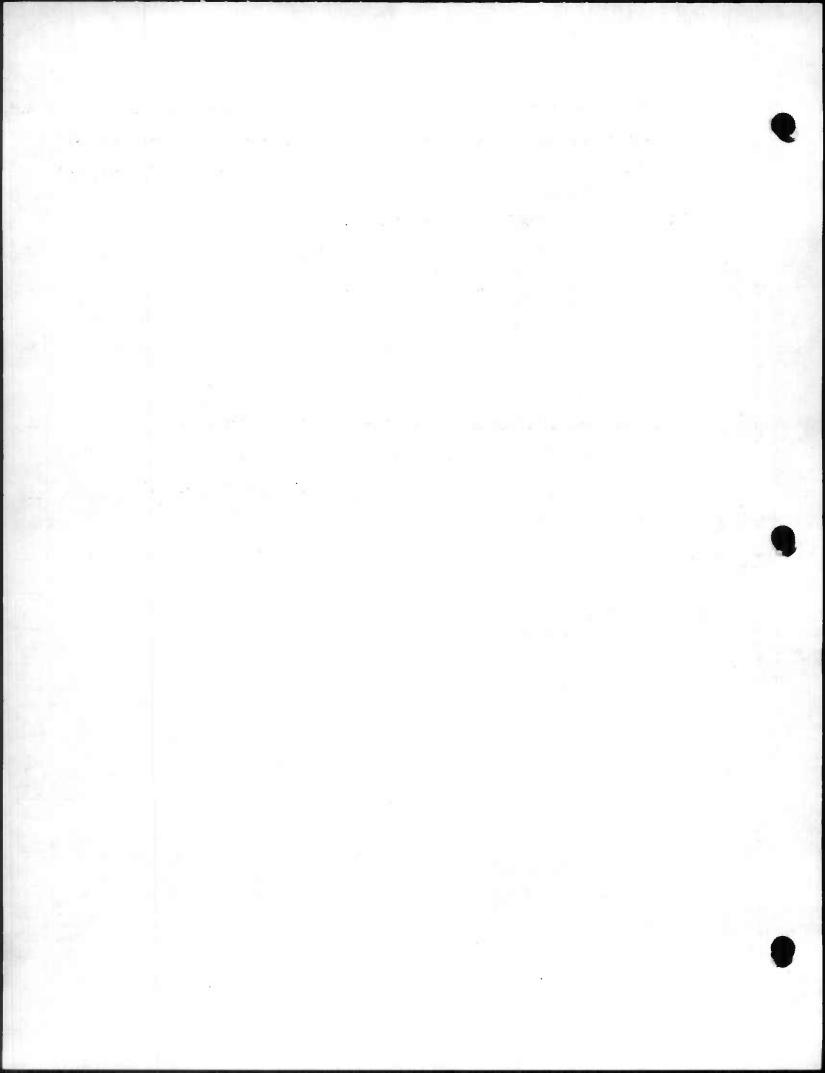
ORIGINAL

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

22,1998



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Output

Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUARY 17, 1999 **Physician** 5:20 am KEITH WILBUR CRITES, SR. /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner ANNE ARUNDEL CO. CROFTON CONVALENCENT & REHAB. CENTER CROFTON If Under 1 Year If Under 24 Hrs. 9. Birthplaca (State or Foreign Country) W. Virginia 8. Date of Birth April 1 07 1928 7. Age (In yrs. last birthday) **Funeral** Months Hours 234-38-8833 10XM 20 F Director Usual Residence of Decedent Maryland 10a Stete 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at Millersville Anne Arundel Co. Md. 1 ☐ Yes 2 No Director the 10e Street and Number 10f Zio Code 10g. Citizen of What Country? USA 21108 628 Cecil Ave. Apt. C Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 XYes 2 NoWWII Specify White 1 ☐ Yes 2 No Specify: 21215-0020 py 3€ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other treumatic event, the Median and E. Dept. of Balto. City Elementery/Secondery (0-12) College (1-4or 5+) Highway Laborer Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ruth Shooke Jesse Crites 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 638 Cecil Ave., Millersville, Md. 21108 (Daughter) Ruth N. Mayes 20b. Pleca of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burlet 2 Cremation 3 Removel from State Meadowridge Memorial Pk.2/20/99 Elkridge, Md. 4 Donetion ▲ Other (Specify) 21. Signeture of Juneral Service Licenses 22. Name end Address of Facility McCully-Polyniak Funeral Home P.A. 130 E. Fort ave. Baltimore, Md. 21230 23a. Part¹. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel /Medical diseese or condition resulting in deeth) Examiner Examiner physicien and the buriel-transit The law requires that the death certificate be assecuted Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or es a consequence of): Box 68760 Physician/Medicai Due to (or as a consequence of): USB Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 3 Probably 4 © Unknown t ☐ Yes 2 ☐ No ANCUM OMA Records. Completed by 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☑ No certificate Division of Vital or Attending Physician: Be 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Other: 45XNursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending n 24 hours after death.

• Funerel Director: Aft
pletaly filled in by the fur 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completaly fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of cap 38958 MID

State Registrar

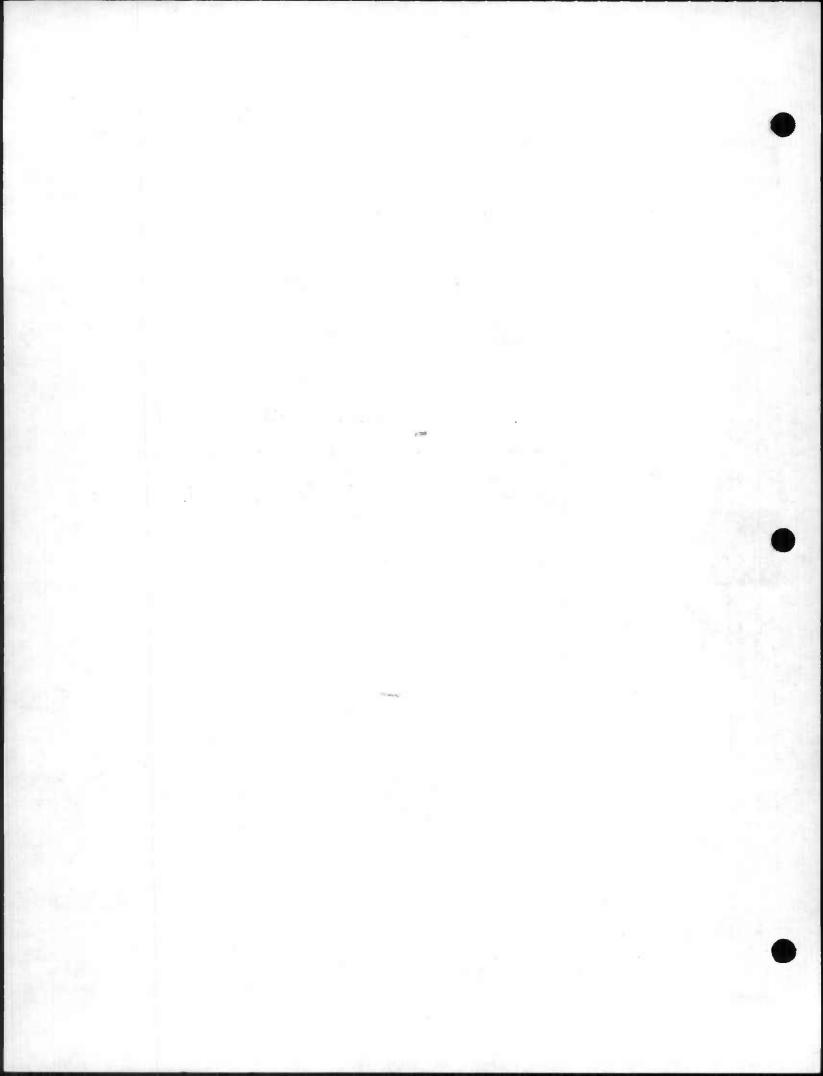
DHMH 16 Rev 6/95

Road #106 odenton MD 21113

address of person who completed cause of death (Item 23a) (Type, Print)

32/ Registrer's Signeture

Singh EB 2 3 1999



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Nor 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** February Chambers 2:30 P.N 18 au 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mercy Hospital Baltimore N/A If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Months Days 1□ M 21 F Yrs. 166 14 5954 84 Director Pennsylvania Usual Residence of Decedent the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits parmit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any Injury or other traumatic event, the Medical Example ment by norfiled at once. 1 Yes 2 □ No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 600 Light Street Apt. 525 21230 U.S. Funeral Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status I ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify þ White 3€ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16h Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) 12th Copy Holder Sun Paper 18. Mother's Nama (First, Middla, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) James M. Koch Lulu V. Hagey 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Larry Chambers / son 105 Franklin Avenue Baltimore, Maryland 21225 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State 2/20/99 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) Cedar Hill Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Gonce Funeral Home P.A. monuscuelle secome 4001 Ritchie Highway Baltimore, Md. 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Physician Immediate Cause (Final disease or condition rasulting in daath) /Medical Asthma Examiner Due to (or as a consaguance of) Examine obstructive physician and the burief-trensit the death certificate be axecuted Sequentially list conditions, if any, leading to immediata causa. Entar Undarlying Cause (Disaase or Injury that initiated events resulting in death) Last Oronary artery

Due to la as a consequence pri: P.O. Box 68760. disease Physician/Medical as t esn 23b. Did tobacco use contribute to the cause of death? ed by the a Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. fibrillation 1 Yes 2 No 3 Probably 4 Unknown signed b Division of Vital Records, p page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? Completed 1 🗆 Yes 2 X No 1 ☐ Yes 2 No blancama certificate or Attending Physician: 25. Was casa referred to medical axaminer? Be 26. Placa of Daath (Check only one) Hospital: 1 ☐ Inpatient 2 ★ER/Outpatient 3 ☐ DOA 1□ Yas 2N No Other: 4 □ Nursing Home 5 ☑ Residence 6 □ Other (Specify) 10 this funaral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how Injury occurred 27 Manner of Death 28c. Injury at Work? After 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Hospital 24 hours 1 Certifying Phyaician: To the best of my knowledge, death occurred et the tima, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and placa, and due to the ceuse(s) end menner stated. 29a. Certifier edicai completaly (Check only within 2 29b. Signature and title of certifier 29c. License number 29d. Date signad (Month, Dey, Year) 18,1999 D40363 February 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Dept. of E.M

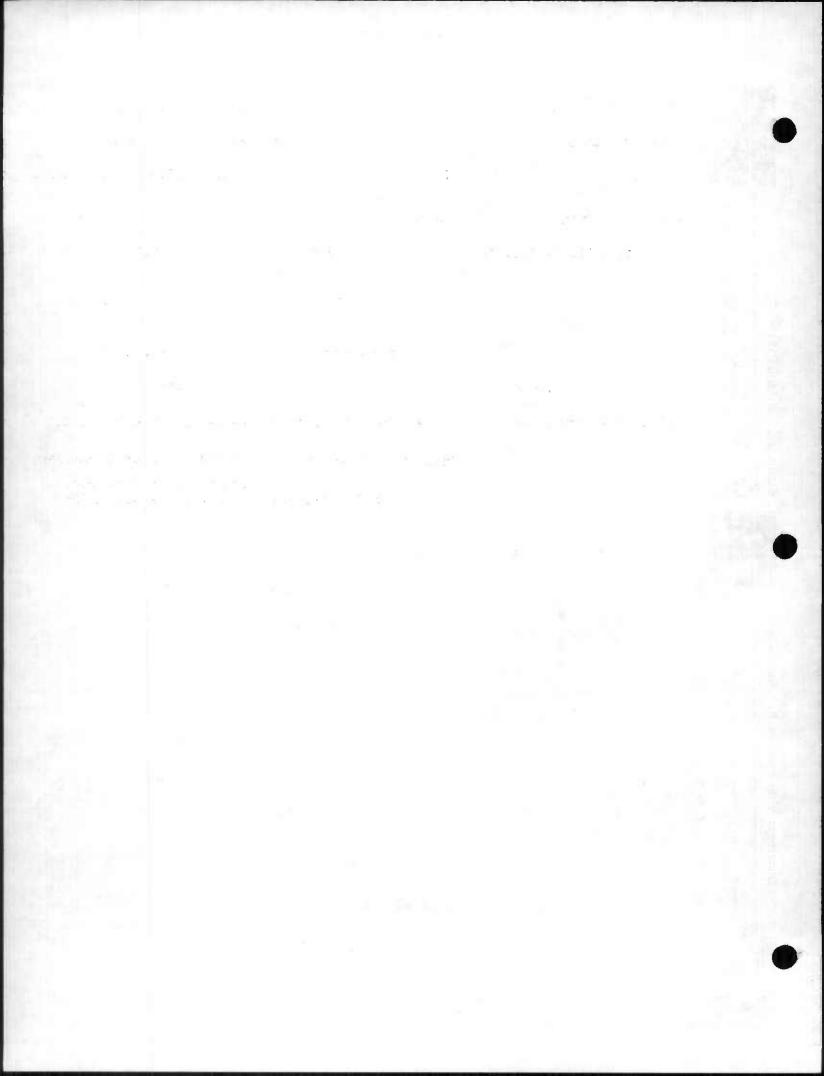
DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Dey, Year)

Mercy 32. Registrar's Signature

Medical



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** 09:45 FEBRUARY IS EDRGE CLEMENTS 1999 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner BALTIMORE
If Under 24 Hrs. 8. Date of BAYULEW MEDICAL JOHNS HOPKINS 5. Social Security Number 219–12–5063 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) **Funeral** Months Deys Hours Min. XXM 2DF Yrs 73 APRIL 26,1925 Director VIRGINIA Usual Residence of Decedent with the Meryland 10e. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be not their at XXYas 2 No Director MD N/A BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3203 LEVERTON AVENUE 21224 U.S.A. daath Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 CNo If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, Whita, atc. parmit. Pegas 1 end 2 should be filed within 72 hours effer bepartment of Haalth and Mental Hygiene. Important: If item 27 is marked other than "naturel", or has any injury or other traumate. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ◯ No Specify: Specify WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) SUPERVISOR WATER DEPARTMENT 18 Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) RICHARD CLEMENTS BESSIE MARSHALL 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19e. Informent's Neme/Reletionship (Type, Print) SHIRLEY A. CLEMENTS - WIFE 3203 LEVERTON AVENUE BALTIMORE, MD 21224 20b. Plece of Disposition (Nema of cemetery, crametory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) OAK LAWN CEMETERY 2/18/99 BALTIMORE, MARYLAND 22. Name end Address of Fecility CHARLES S. ZEILER & SON, INC. 23a. Pent. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest,

Approximate

Approximate Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) ardiomyopath Schemic Examiner Due to (or es e consequence of) Examiner Artery Due to (or es e consequence of) Sequentially list conditions, if eny, leading to immediate causa. Enter Underlying Causa (Diseasa or injury thef initiated events resulting in death) Lest ettanding physician and for use as the bunel-tren that the death cartificete be exec Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or es e consequence of): use as t 23b. Did tobecco use contribute to the cause of deeth? signed by tha e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 ☐ Unknown bstructive disease þ 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24a. Was en eutopsy Completed neumonia pega 2 s 2 0 No 1 ☐ Yes 2 No 1 Yes cartificeta or Attanding Physician: funaral director, Be 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 Unpatient 2 ER/Outpetient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury of Work? Certification: Aftar 5 Pending investigation s after death. 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 28e. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 3 Suicida 28f. Location (Straet end Number or Rural Routa Number, City or Town, Stete) 4 Homicide 24 hours Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Usedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar edical complately (Check only one) To the I within 2 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture egg Leah Wolfe, MD of person who completed causa of death (Item 23e) (Type, Print)

Johns Hopkins Bayview Medical Center, Baltimore

Re.

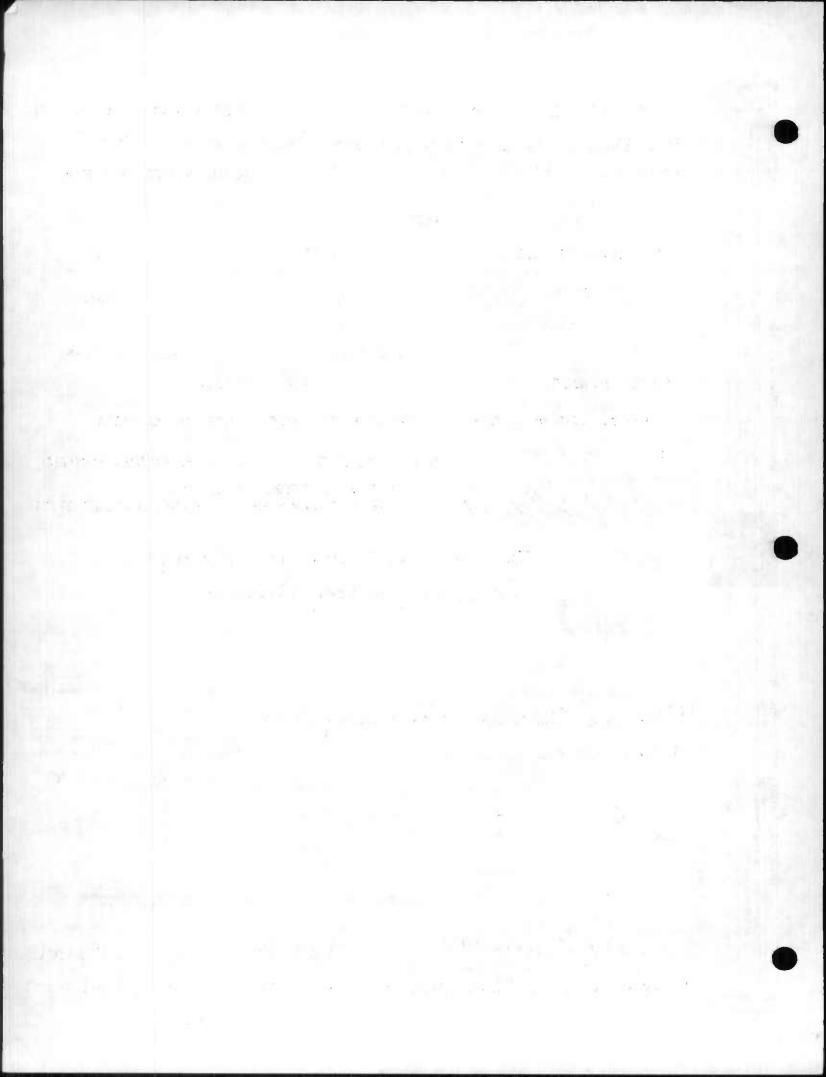
State Registrar wolfe

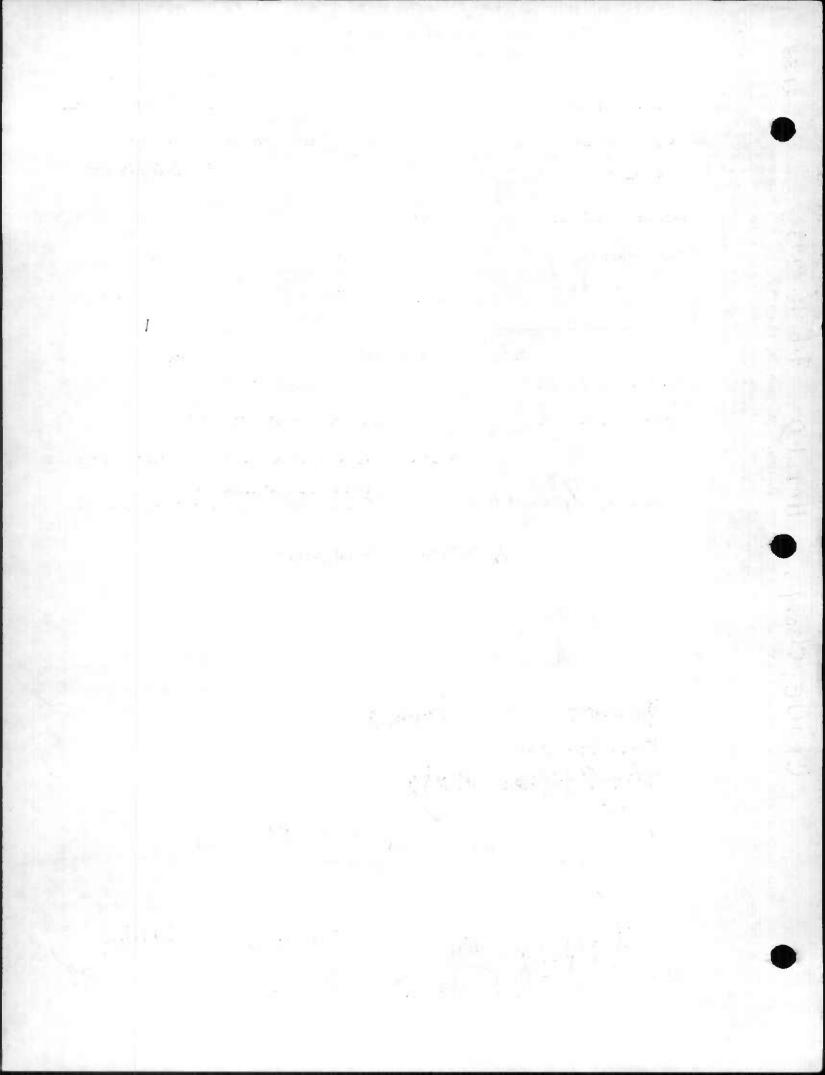
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32: Registrer's Signetur

31. Dete filed (Month, Dey, Year)

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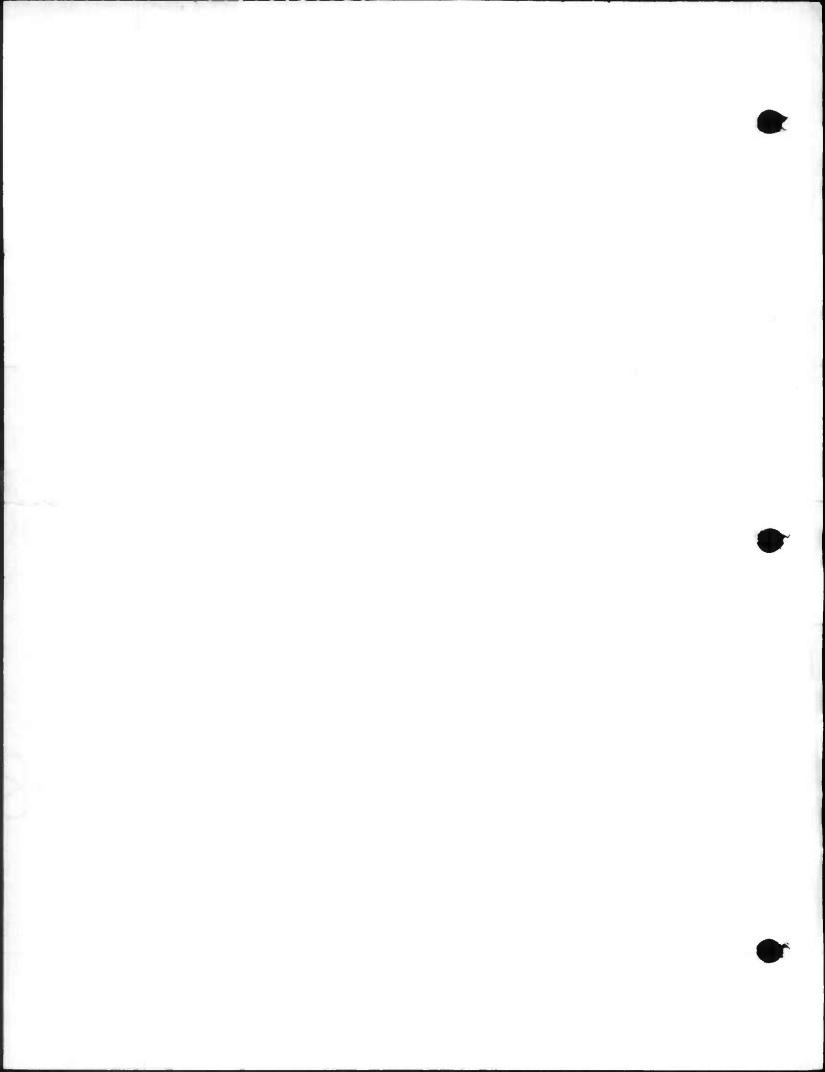




60. BALTIMORE, MARYLAND 21215-0020	within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	O THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page S should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	vent, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760.	TO THE HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the : be filed within 72 hours after death with the State Dept. of Health and Memal Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF I		MENTAL HYG		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF OFAT	н	3. TIME OF DEATH
	Ruby Snow C1	1	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	y 16,199	BIRTHPLACE (State or Foreign
	236-40-8792	1 🗆 M 2 💢 F	78 YRS.	MONTHS DAYS	HOURS MIN.	April 9.	ir)	Country)
~	9a. FACILITY NAME (If not institution, give	street end number)		9b. CITY, TOWN	OR LOCATION OF D			Y OF DEATH
TO	64 East Main ST	treet		Hanco	ck		Washi	ington
DIRECTOR	10e. STATE 10b. COUNT			, TOWN OR LOCA	TION			10d. INSIDE CITY LIMITS?
	MD Was	hington	На	ncock	f. ZIP CODE		10g. CITIZE	1 X YES 2 NO
FUNERAL	64 East Main	Street			21750		USA	A
	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO	If yes, sp	pecify Cuban, Mexico	NIC ORIGIN? (Specifien, Puerto Rican, etc	y Yea or No- 14	I. RACE — American Indian, Black, White, etc.
ВУ	3 X Widowed 4 Divorced	IF YES, GIVE WAR OR D	DATES	1 □ YES	3 2 X NO Specif	/y:		White
ETED	15. DECEDENT'S EDU (Specify only highest grad	e completed)	16e. DECEDENT'S (Give kind of w life. Do NOT us	rork done during me	ON ost of working	16b. KIND OF	BUSINESS/INDUS	STRY
APLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	Homema			Own	Home	
COMPL	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First, Middle, Ma		
BE	George Lownan 190. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street		Silvers Route Number, City o	Your State Zin Co	ordel
유	Larry L. Stotle	er/Son				Washing		
	20e. METHOD OF DISPOSITION 1 St Burlel 2 Cremetion 3 Ren	noval from State	b. PLACE AND DATE C	has almost			LOCATION — CIT	
	4 Donation 5 Other (Specify)	conget A ()	phor's Cr	22 NAME A	NO ADDRESS OF EA	ICII ITY		rings, W
	March 1	2 HILL	0.7			Home, P .Hancock		750_0368
	23. PART I. Enter the diseases, or	complicatione that cause List only one cause on e	d the death. Do n	ot enter the mo	ode of dying, suc	ch es cerdisc or r	eepiratory arrea	t, Approximate
	iMMEDIATE CAUSE (Final disease or condition			1- 1	-1 +			Interval Between Onset and Death
	resulting in death)	e. Acute DUE TO (OR AS	A CONSEQUENCE OF	elled in	farche	~		immed
N	Sequentially list conditions,	D		1 1 0	w			23 yrs.
ATIC	If any, leading to immediate cause. Enter UNDERLYING	DUE POYOR AS A	A CONSEQUENCE OF):				
TE	CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS /	A CONSEQUENCE OF):				
CERTIFICATION		d,						
AL	PART II. Other significant condition	ns contributing to deeth b	out not reaulting I	n the underlyin	g cauae given in	Part I. 24s. WA	S AN AUTOPSY REORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
MEDIC						1 _ YE	s 2 NO	OF DEATH?
ž	DID TOBACCO USE CONT	RIBUTE TO CAUSE C	OF DEATH YE	S D NO	UNCERTAI	N D		1 TYES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	H (Check only one)				
HYS	1 YES 2 NO 27. MANNER OF CEATH	1 Inpetient 2 ER/Outs 28e. DATE OF INJURY	28b. TIME	4 Nursing Hon	JURY AT	8 Other (Specify)	OW INJURY OCCUP	RED
ВУ Р	1 Natural 5 Pending Investigation	(Month, Day, Year)	ILNI	JRY WO	PRK? YES 2 NO	204. 02001.02 11	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE OF INJURY building, etc. (Spec	f — At home, ferm, a	treet, fectory, offic	•	28f. LOCATION (St City or Town, S	reet end Number or tate)	Rural Route Number,
						to the cause(s) and	menner ee steled	
PLET	29e. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the beat of my know	rledga, death occurre	d at the time, date	end place, end due			
OMPLET	(Check only 1 CERTIFYING PHYS	ICIAN: To the best of my know ER: On the bests of examination						couse(s) and manner es stated.
BE COMPLETED	(Check only 1 CERTIFYING PHYS	ER: On the besis of examination				time, date end plac	, and due to the c	
ш	(Check only one) 2 MEDICAL EXAMIN	ER: On the besis of examination	n end/or investigation	n, In my opinion, o	leath occured at the	time, date end plac	, and due to the c	ceuse(s) and manner es stated.
BE	(Check only 1 AL CENTIFYING PHYS ONE) 2 MEDICAL EXAMINI 29b. SIGNATURE AND TITLE OF CERTIFIE Frank B. Thomas	ER: On the besis of examination	an end/or investigation ATH (ITEM 27) (Type,	n, In my opinion, o	leath occured at the	time, date end plac	, and due to the c	ceuse(s) and manner es stated.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 1. Decedant's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month 06:29AM Samuel H. Desch February 19, 1999 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva straat and number) Anne Arundel General Hospital Annapolis Anne Arundel If Under 1 Year if Under 24 Hrs. 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 8. Data of Birth (Month, Day, Year) 1 M 2 □ F Days Hours 217-05-1073 Yrs. 86 Sept. 15, 1912 Maryland Usual Residence of Decedant 10e. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Coda 10g. Citizan of Whet Country? 5201 River Crescent Drive 21401 USA 12. Was Decedant Evar in U.S. Armad Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - Amarican Indian. Black, White, etc. 1 X Yes 2 □ No If Yas, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade completed) Collega (1-4or 5+) Elamantary/Secondary (0-12) Executive Pepsi Cola 17. Father's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumame) Ferdinand Desch Sarah Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Apt. 3 Samuel H. Desch, Jr./Son 37 Sargent St. Cambridge, Maine 02140 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State Mount Olivet Cemetery 02/24/99 Nashville, TN 4 Donation 5 Othar (Spacify) 21. Signature of Funaral Service Licensee 22. Name and Addrass of Facility Gary L. Kaufman F. H. @ Meadowridge Mem. Park, Inc 7250 Washington Blvd., Elkridge, MD 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata interval Batween Onset and Death immediata Causa (Final disaasa or condition resulting in daath) as a consequence of Due to (or as a consequence of). Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Inknown 24b. Wera autopsy findings available prior to 24a. Was an autopsy performad? complation of cause of death? 1 Yes 2 No 20No 26. Place of Death (Check only one) Hospital

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funerai

λq

Completed

Be

Funeral

Director

7 is marked other than "nature!", or items 23a or 28a-f show treumstic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours efter death v Department of Health end Mental Hygiene. Important: If Item 27 Is marked other than "naturel", or Items 23, any Injury or other traumatic event, "" Medical Examples managed."

Baltimore, Maryland 21215-0020

with the Maryland

Examiner sician and buriel-transit the 80 signed by the a pege 2 s hes

requires that the death certificate be executed

Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760,

director

Physician/Medical þ Completed Be 10 Certification:

certificate this funeral after death. filled in by

To the Hosp within 24 hos To the Fune completely fi

24 hours a

Registrar

edicai

29b. Signature and title of contil

30. Name and address of or

31. Date filed (Month, Day,

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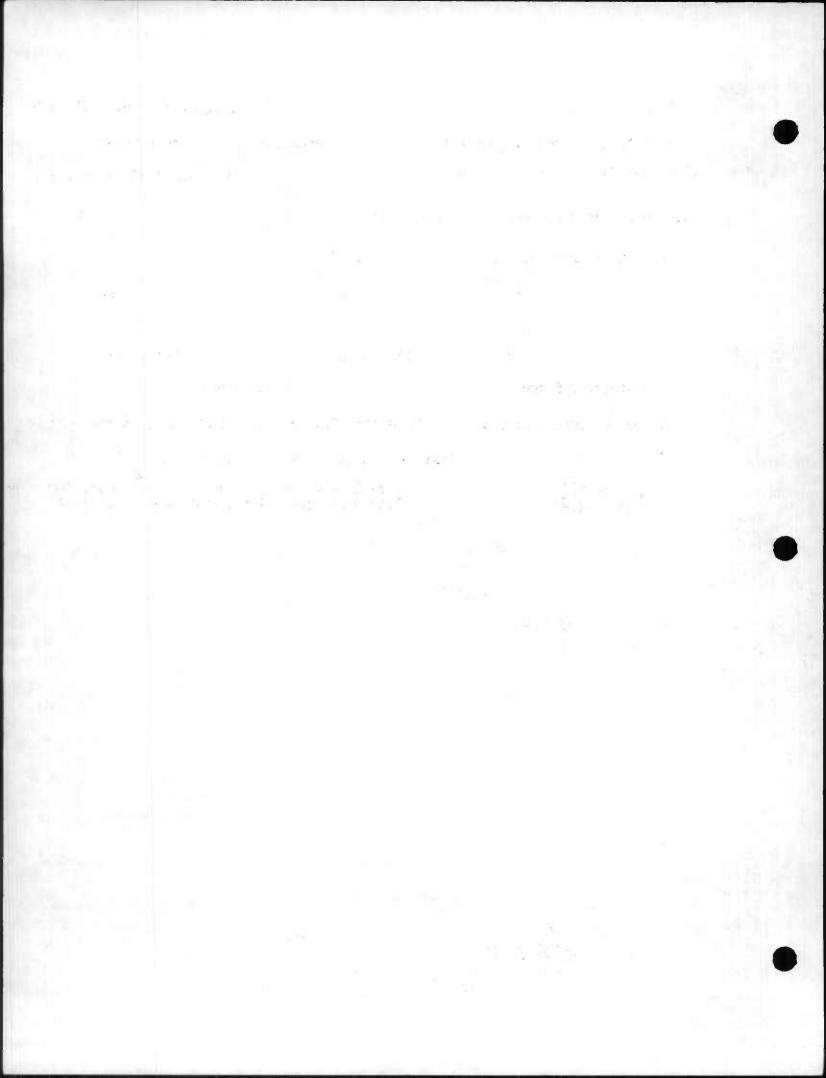
FEB

Sequentially list conditions, if any, leading to Immediate causa. Entar Undarlying Cause (Disease or Injury that Initiated events resulting in death) Last Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes |2 No Othar: 4 Nursing Home 5 Residence 6 Other (Specify) / Inpatiant 2 □ ER/Outpatient 3 □ DOA 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28d. Describa how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 2 Accidant 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide 29a. Certifiar 1 Certifying Physician: To tha best of my knowledga, daath occurred at the tima, data and placa, and due to the cause(s) and manner as stated. (Check only one) 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29c. Licansa numba

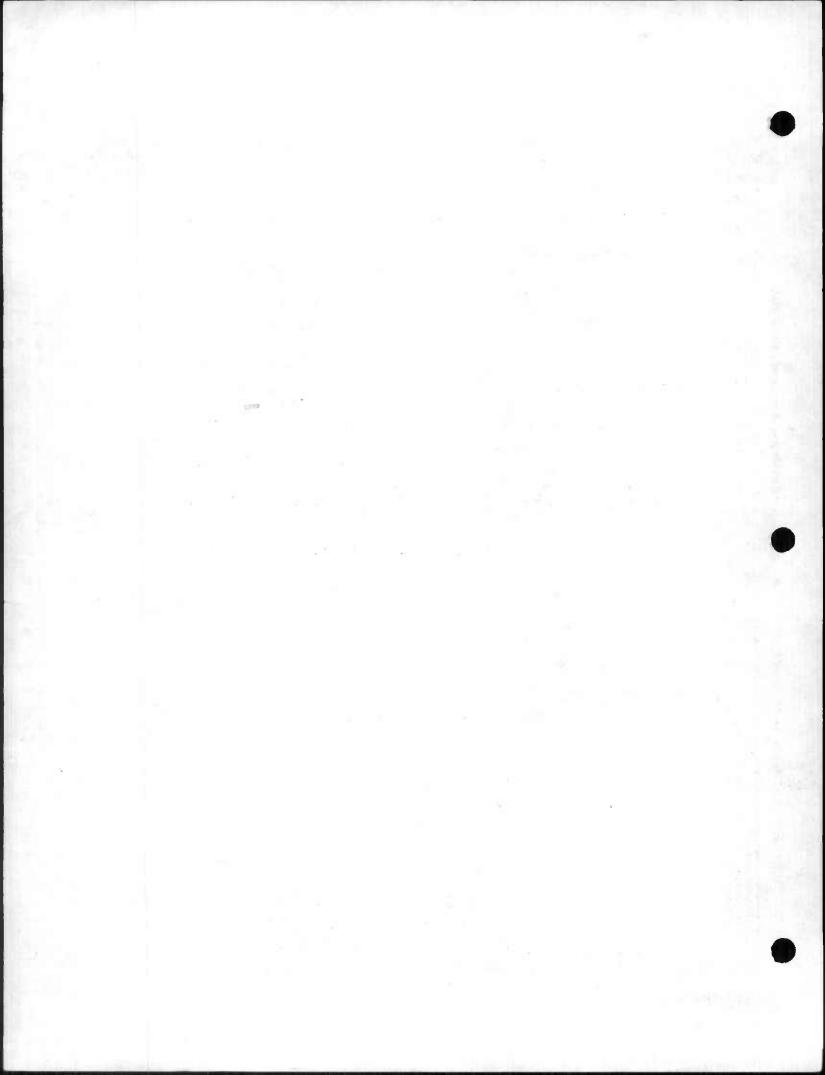
completed cause of death (Item-23a) (Type, Print)

32. Ragistras Signature

29d. Date signed (Month, Day, Year)



			C	ertificate	of Death	Rec	a. No.	
		Decedent's Name (First, Middle, Last)				2. Dete of Death	3. Tima of Death	
Physicia /Medica	HOWARD B DICKE	RSON				Month FEBRUARY	16,1999	7:00 P.M.
Examine	An English Blome /Mand Institution of	re street end number)			4b. City, Town, o	or Location of Death	4c. County of De	eeth
	4928 GATEWAY TE	RRACE			ARBUTU		BALTIM	
Funeral	Sociel Security Number 6. 5	Sex 7. Age (In y	rs. last birthda	y) If Under 1 Months I	Yeer If Under 24 H Deys Hours M		Year) 9. E	Birthplaca (State or Foreign Country)
Director	219-01-5646	78	Yrs.			MAY 26,		VIRGINIA
¥	Usuel Residence of Decedent 10e. Stete 10b. County	10c.	City, Town or	Location				10d. Inside City Limits
Aary a she	MARYLAND BALTIM	IORE /	RBUTUS					1 ☐ Yes 24 ☐ No
the 128s	MARYLAND BALTIM	TOKE F	MDUIUD	10f. Zip C	ode	10	g. Citizen of What	Country?
an or other		ACE		212			U.S.A	
ma 2 Limit	11. Maritel Stetus 1 Nevar Married 2 Married	12. Wes Decedent Ever in	U,S. 13	. Wes Deceder	nt of Hispanic Ongin?	(Specify Yes or No-	14. Race - Ar	merican Indien,
O2(3 ₺ Widowed 4 □ Divorced	Armed Forcas? 1 Yas 2 No 14 Yes, Give Yeer or Detes:	V II	If Yas, specify	Cuban, Mexican, Pu	arto Rican, atc.)	Specify:	hita, etc. VHITE
5-0 72 ho	15. Decedent's E (Specify only highest gra Elementery/Secondery (0-12) 6TH GRADE	ducation		edent's Usuel (Occupation done during most of w	undring 10	6b. Kind of Busines	ss/Industry
Me in 21	Elementery/Secondery (0-12)	College (1-4or 5+)	life	DO NOT use	retired)	VOIKEIG		
Z wage	6TH GRADE		MA	CHINE C	PERATOR		MANUFACTU	JRING
D STREET	17. Father's Neme (First, Middle, Last,					leme (First, Middle, Ma	aiden Sumeme)	
yla marka marka	HOWARD B. DICKERS					DILLON		
Man 12 st 18 m	19a, Informant's Neme/Reletionship (Rural Route Number,		
C 2 00 L	GREGORY D. DICKE			1 CARMA position (Name		SYKESVILLE Dete	MARYLAN Oc. Location - City	
Baltimore, semit. Pages 1 a Separtment of Hea mportant: if Hem my Injury or othe mas.	1 XBurial 2 Cremetion 3	Removel from State	cametery, cr	emetory or other	er pleca)			
Baltim semit. Pa Separtmen mportant my injury ansa.	4 Donetido 5 Other (Specif	LEC			EMETERY	2/20/99	BALTIMOR	RE, MARYLAND
Balt permit. Depart imports any inje	21. Signature of Funarel Service Licer	l'e	H	UBBARD	Address of Fecility FUNERAL HO	ME, INC. JE-BALTIMOR	DE MADVI	AND 21229
	23a. Part1. Enter the diseese, or com shock, or haert failure. List only	plications that caused the de						Approximate
Physician /Medical Examiner	Immediate Cause (Finel disease or condition resulting in deeth)	a. Acteurs						Interval Between Onset end Deeth
		Due to	(or es e cons	equenca of):				
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and al-trar	Sequentially list conditions, if any, leeding to immediate	Due to	(or es e cons	equenca of):				
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Attending or death.	2 Accidant investigation	n		М	1 Yes 2 No			
Division Attack	3 Suicide 6 Could not b determined	e 28e. Plece of Injury - Al building, etc. (Spe	home, ferm, s	street, fectory, o	office	28f. Location (Stre City or Town,		Rural Routa Number,
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F3F8	Munden	luse 1			08780		2/18/	99
	30. Nama and addrass of person who	commenced course of death to	nm 92a) (T	1	00/00	~	1101	
1	DR. ALEJANDRO ME.	IIA - SUITE 1	00 - 40)5 FRED	ERICK ROAD	- CATONSV	ILLE, MA	RYLAND 21228
State	24 Date filed (Month Day Year)	32. Registrar's Sig		1				
State		1	AA	A a a . 10				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3 Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Kichard Dutrow rep 11:10 Am /Medical 4e Fecility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Daafh 4c. County of Deeth Examiner 7641 Greendell Lane Highland Howard If Undar 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dev. Birthplaca (Stete or Foreign
Country) **Funeral** 1 № M 2 □ F Deys Hours Min. Mar 08, Yrs. Maryland 218-30-9422 61 Director Usuel Residence of Decedent filed within 72 hours after death with the Meryland Hygiene. 10e. Sfate 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Howard Highland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Counfry? 7641 Greendell Lane 20777 USA Funeral 14. Rece - American Indian, Bleck, White, atc. 12. Was Decedanf Evar in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Navar Merried 2 Merried Specify: White 1 ☐ Yes 2 No à 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Spacify only highast greda completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Grade 10 Horse Trainer Horse Racing other permit. Pages 1 end 2 should be file Department of Health end Mentel Hy important: If item 27 is marked othe any Injury or other traumatic avent page. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Leroy Dutrow Edna Viola Bowman 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 7641 Greendell Lane, Highland, Maryland 20777 Victoria Dutrow /spouse 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, Stete Data 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removel from State 2/20/99 Hagerstown, Maryland Rest Haven Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signety e of Funeral Service Lice 22. Nama and Addrass of Facility Donaldson Funeral Home, P.A. Wit 313 Talbott Ave. Laurel, Maryland 20707-4389 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest. Ist only one cause on each line. Approximete Intervel Between Onset end Death **Physician** 6 months /Medical Immediate Cause (Finel End stage Cancer pancrea disease or condition resulting in death) Examiner Due to (or as e consequence of): Physician/Medical Examiner ig physician end as the burial-transit thet the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or es e consequence of): thet initieted events resulfing in deeth) Lest Due to (or es e consaguenca of): ettending 950 Por Pert II. Other significant conditions confributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown signed b by 24e. Wes en eutopsy performed? 24b. Were eutopsy findings Completed evailable prior to completion of cause of deeth? ate hes l 1 ☐ Yes 2 No 1 ☐ Yes 2 No Hospital or Attanding Physician: 24 hours efter death. 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpetient 2 ER/Outpetient 3 DOA 2 1 Yes 2 No this 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred Certification: After 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident ector: / 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 3 Suicida 6 Could not be 28e. Pleca of Injury - At home, farm, streef, fectory, office building, etc. (Specify) In by 4 ☐ Homicide To the Hospital within 24 hours of To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end pleca, end due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, and due to the cause(s) end manner stated. edicai 29a. Certifier 29d. Deta signed (Month, Day, Year) 29b. Signeture end title of cartified 29c. License number MD

Registrar

P.O. Box 68760.

Division of Vital Records.

31. Dete filed (Month, Day, Year) State

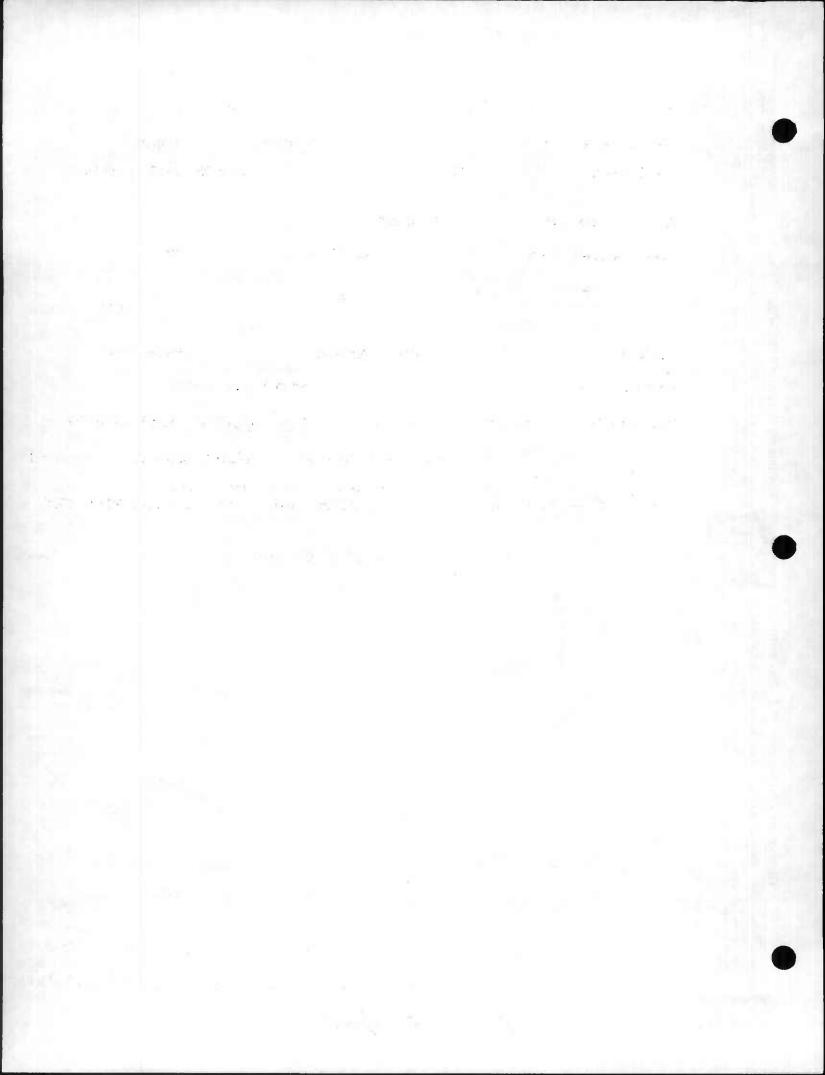
FEB 2 3 1999

JACOB CHERIAN

30. Name end/address of person who complated cause of deeth (Item 23e) (Type, Print)

Patrixent Medica 32. Registrar's Signeture

Two Knoll North DR. Columbia 21045



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** Richard P. Demski February 17 1999 9:32 A.M. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Harbor Hospital Center Baltimore If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 8 9 26 6. Sex 1 M 2□ F 5. Social Security Number If Under 1 Yaar 7. Age (In yrs. last birthday) Birthplace (Steta or Foraign Country) **Funeral** Months Days 216 20 8020 72 Yrs. Director Maryland Usual Residence of Decedent with the Meryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or froms 23a or 28a-f show treumstic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5220 Disney Avenue 21225 U.S. Funeral daeth 12. Was Decedant Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Raca - Amarican Indian, permit. Pegas 1 and 2 should be filed within 72 hours effar of Departmant of Health and Mentel Hygiane. Important: if item 27 is marked other than "natural", or then any Injury or other treumatic event. Black, White, etc. 1 XYes 2 No If Yes, Give Year or Datas: W.W. II 1 Never Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: LU MITE by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Giva kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesman DeGrange Lumber Co. 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Michael Demski Helen McShane 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Eleanor P. Demski wife 5220 Disney Avenue Baltimore, Maryland 21225 20b. Placa of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20e. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/20/99 Cedar Hill Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility 21. Signature of Funeral Service Licensee Gonce Funeral Home P.A. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Baltimore, Md. 21225 Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final VENTRICULAR ARRHYTHMIA MINUTES disaase or condition resulting in death) Examiner Due to (or as e consequence of):

1 SCHEMIC CARDIOMY OPATHY Examiner 10-12 YEARS physician and tha buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last P.O. Box 68760 that the death cartificete be Physician/Medical Dua to (or as a consaquance of): esn Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t OBSTRUCTIVE PULMONARY 1 No 3 Probably 4 Unknown by 24b. Were autopsy findings aveilable prior to 24a. Wes an autopsy Completed completion of causa of death? has 1 Yes 2000 1 ☐ Yas 3 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Rasidanca 6 Other (Specify) 1 Yes 20 No 3 200A 2 1 Inpatient 2 ER/Outpatient this funaral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: Affar 5 Pending investigation or Attendination after daeth. 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 24 hours a Funeral D ix Certifying Physician: To the best of my knowledge, death occurred et the time, date and plece, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end plece, end due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) within 2 To the 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certifle 29c. Licansa number actifi 30. Name and address of person ymo completed cause of death (Item 23a) (Type, Print)

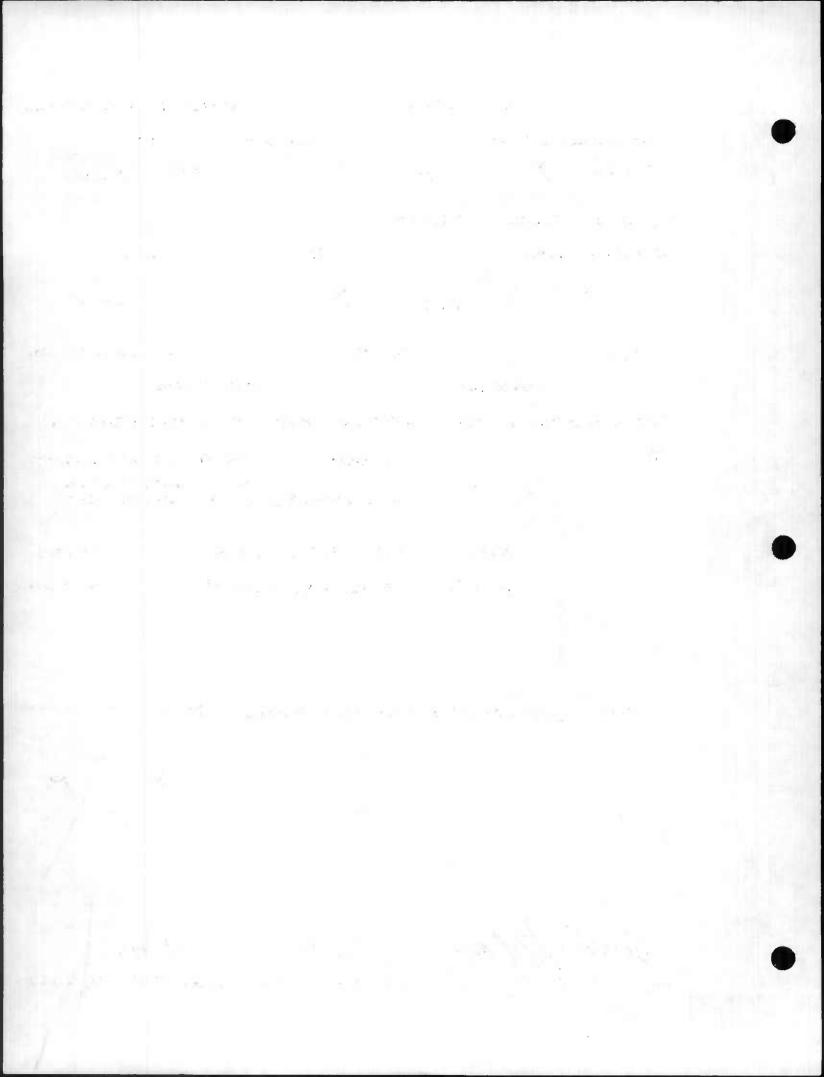
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State Registrar CARLOS D. SCEEC

31. Date filed (Month, Day, Year)
FEB 23 1999

32/Registrar's Signature

1406 S. CRAIN HWY #106 GLEN BURNIE NO ZIOGI



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Dete of Death Month Yaar 4c. County of Death 14:00 1999 AVIS TEBRUARRY LARA 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) BAYVIEW MEDICAL HOPKINS CENTER | SALTIMORE if Under 24 Hrs. 8. Date of I JOHNS 7. Aga (In yrs. last birthday) 57 Yrs. Birthplaca (Stata or Foreign Country) 5. Social Security Number Months Days Min 1 M 2 F Hours 218-16-0273 Jan.31 1942 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. fnsida City Limits Md. **Baltimore** 1 Yas 2 No Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 5306 Valiquet Ave. 21206 USA 12. Was Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 Yas 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) Elementery/Secondary (0-12) College (1-4or 5+) 8th 18. Mother's Name (First, Middla, Maidan Sumama) 17. Father's Name (First, Middla, Last) Ursaline Hart Ghuhward Davis 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Steven Jacobson / lawyer 4550 Montgomery Ave. Bethesda MAryland 20814 of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cematary, cramatory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 2/22/99 Baltimore Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Home of Essex 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List dry one cause on each line Approximate Interval Between Onsel and Death Immediate Cause (Final disease or condition resulting in death) typoxemia Due to (or as a consequence of) Respiratory Due to (or as a consequence of istrass Syndrome Sequentielly list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events neumonia Due to (or as a consequence of) resulting in death) Last 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 28b. Time of

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Physician

/Medical

Examiner

Director

Funeral

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Completed

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Item 27 is marked other than "natural", or items 23s or 23s-f show other traumetic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Haaith and Mental Hygiana. Important: if Item 27 is marked other than "natural", or fren any lojury or other traumatic event, the Medical Exempted ORGE.

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3altimore, Maryland 21215-0020

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To the Hospital within 24 hours a To the Funeral L

State Registrar Part fi. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Sepsis Jaun's Syndrome 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28e. Place of injury - At home, farm, street, fectory, office building, etc. (Spacify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) and manner es steled.

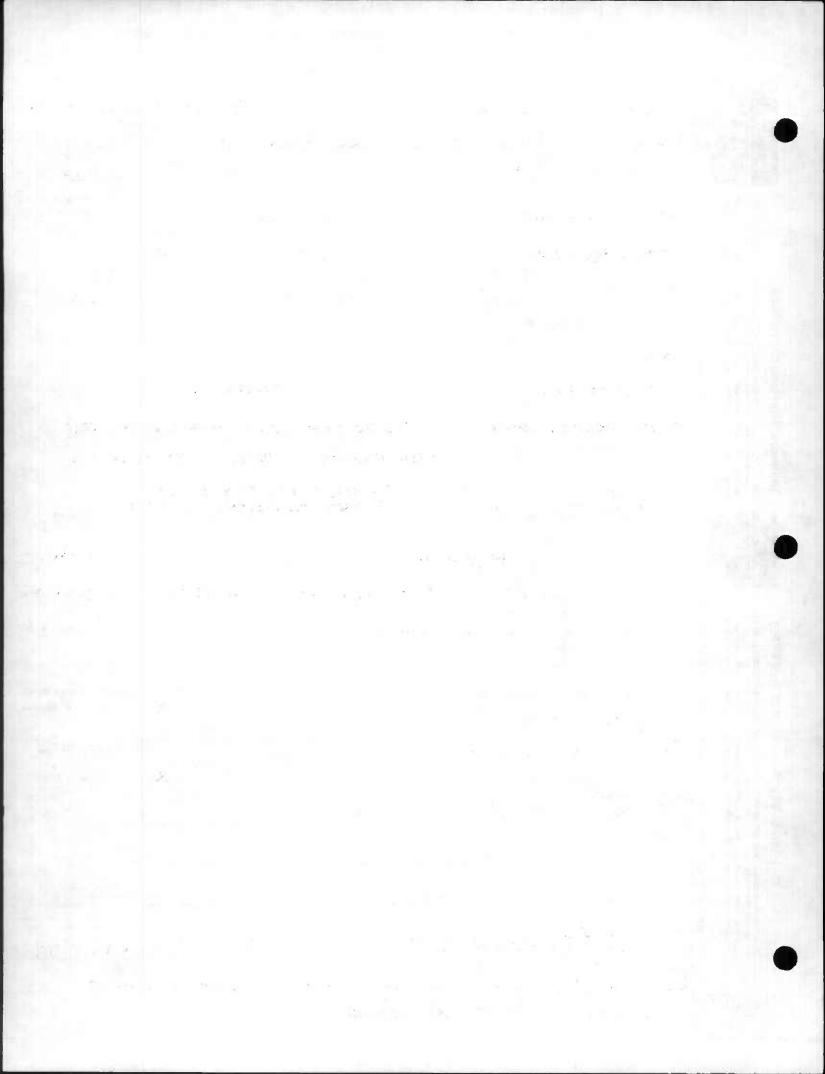
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, end due to the ceuse(s) and manner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifier eah Wolfe, MO

FEBRUARY 18,1999

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) LEAH WOLFE, MD JOHNS HOPICINS BAYLIEW MEDICAL CONTER, BALTIMORE

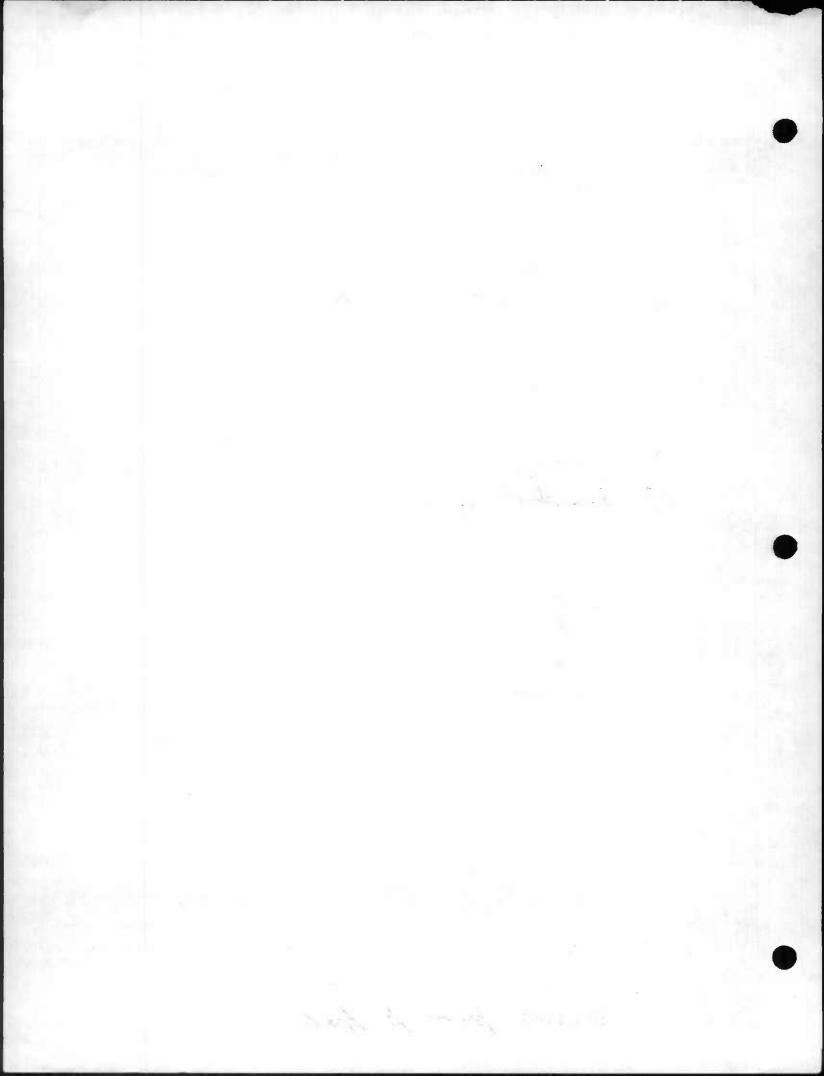
31. Data filed (Month, Day, Year) FEB 2 3 1999

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

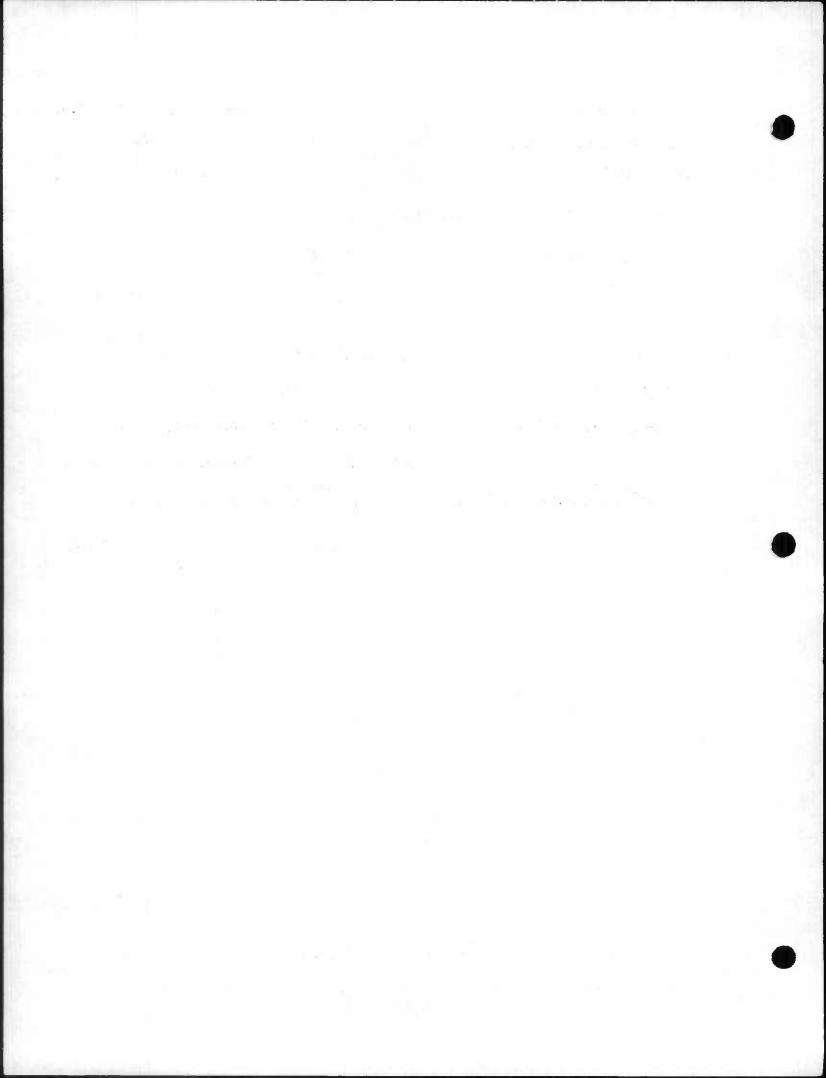
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or 28	ire	10e. Street and Nur	mber				10f. Zip Cod	а .		10	g. Citizen of 1	What Cour	ntry?
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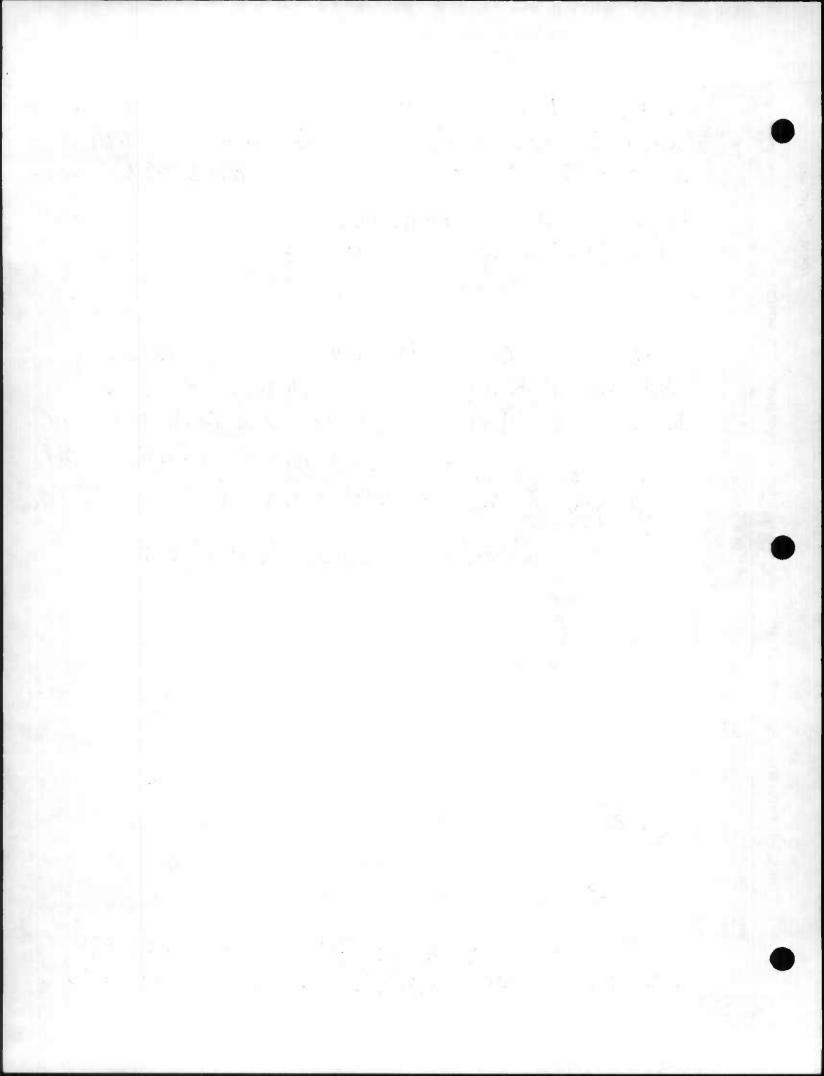
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State of Maryland / Department of Health and Mental Hygiene

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		• •	Department of Health and Certificate of Death		05245
Physician /Medical Examiner Funeral Director	1. Decedent's Name (First, Middle, Last) EMMA 4a Facility Name (If not institution, give st 2216 5. Social Security Number 546-36-4893 Usual Residence of Decedent	reet and number AUE, M 2 F 7. Age (In yrs. last bi	4b. City, Town, or Balt inthday) If Under 1 Year If Under 24 Hrs Wonths Days Hours Min	more 8. Date of Birth	3. Time of Death Year 9 12 36 P M of Deeth N A 9. Birthplace (State or Foreign Country).
ith the Meryland or 28e-f show or notified at	10a. State 10b. County A 10e. Street and Number	Ba	m or Location The Code 10f. Zip Code	10g. Citizen of V	10d. Inside City Limits 1 ☑ Yes 2 ☐ No //hat Country?
end 2 should be filed within 72 hours after death with the Meryland salth and Mentel Hygiena. n.27 is marked other than "natural", or frems 23a or 28a-f show her traumatic event, he Medical Evanther must be notified at the traumatic event, he Medical Evanther must be notified at To Be Completed by Funeral Director	11. Merital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 — Yes 2 2 No If Yes, Give Year or Dates:	13. Wes Decedent of Hispanic Origin? (s If Yes, specify Cuban, Mexican, Puer 1 Yes 2 No Specify:		571 e-American Indien, k, White, etc. Black
be filed within 72 ho ntel Hygiena. of other than "natur. event, the Moulcal Be Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) 16a College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work) Ale DO NOT use retired) 18. Mother's Na	rking 16b. Kind of Bu	ndry
nd 2 should be filed lith and Mentel Hygi 27 is marked other r traumatic event, II To Be Cc	William H. 19a. Informant's Neme/Relationship (Typ) MS. TOSIE BE	King Prints 19 2 Cher 2	b. Mailing Address (Street and Number or A	ie B. G	ay
permit. Pages I end 2 Depertment of Health i Important: If Item 27 is any Injury or other tre once.	20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses	omoval from State 20b. Place of compton	of Disposition (Name of pay, crematory or other place) utus Mem. Fark 22. Name and Address of Facility		City or Town, State O, Co, Md.
Physician /Medical	23a. Part I Enter the disease, or complice and or heart filture. List only one immediate Cause (Final	ations that caused the death. Do	not enter the mode of dying, such as cardia	correspiratory errest.	Approximate interval Between Onset and Death
Examiner	disease or condition resulting in death) a.		consequence of):	(CCI GEN	
a fola	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last	Due to (or as a	consequence of):		
d by the letached	Part II. Other significant conditions cont	ributing to death but not resulting	In the underlying cause given in Part I.	23b. Did tobecco use co	ntribute to the cause of deat
The law requires the state has been signed page 2 should be d				24a. Was en eutopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
	25. Was case referred to medical		28 Place of De	1 Yes 2 No	1 Yes 2 No
nysician: The law his cartificate hes t il director, paga 2 s To Be Compi	examiner?	ospital: 1 Inpatient 2 ER/C	Other	1/	er (Specify)
To the Hospital or Attending Physician: within 24 hours after death. So the Funeral Director: After this cartific completaly filled in by the funeral director, Medical Certification: To Be (27. Manner of Death 1 Natural Accident 3 Suicide 6 Could not be	(Month, Day Year)	Time of Injury at Work? M 28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occur	
urs after of ral Direct fled in by	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)		28f. Location (Street and Numb City or Town, State)	
To the Hospital within 24 hours to the Funeral completely filled	(Check only 2 Medical Examinone)		pe, death occurred at the time, date and place and place and occurred at the time, date and place	urred at the time, date and place,	and due to the cause(s)
within com	290. Signature and title of certifier	amon	29c. License number 3224	29d. Date signe 29d. 27	d (Month, Day, Year)
103	20. Name and address of person one ope	npieted cause of death (item &	(Type Print) BALTIMO	RE 21	223
State	31. Date filed (Month, Day, Year)	32. Registrar's Signature			



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 1910 PM MILDRED DOROTHY EDWARDS FEB 15 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) BALTIMORE SAINT HUSPITAL, 900 (ATUN AUS A-GNES If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 M 2 X F Yrs 215-16-5541 BALTIMORE JUNE 16,1919 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No BALTIMORE MARYLAND N/A 10e. Street and Number 10f. Zin Code 10g. Citizen of Whet Country? U.S.A. 21229 38 N. ATHOL AVENUE 14. Race - American Indian, Black, White, etc. 12. Was Decadent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 N Widowed 4 □ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 12th GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) JOSHUA LEVERING BOWEN, SR. MILDRED CAROLINE BUTLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 161 CHERRYDELL ROAD - CATONSVILLE, MARYLAND A. CHRISTINE MORGAN (DAUGHTER) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removel from State BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) DRUID RIDGE CEMETERY 2/28/99 21. Signature of Funere) Service Licensee 22. Name end Address of Facility HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MARYLAND 21229 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STAGE COPD Due to (or as a consequence of) Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest Due to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobacco usa contribute to the causa of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how Injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

EDWARDS, MILDRED DOROTHY physician end the buriel-transit 98 use signed by t certificete hes b lirector, page 2 s After this unerai deeth. efter deetl Director: filled in by 24 hours

Physician/Medical Examiner by Completed Be To Certification:

edical

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show

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Completed

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Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland nent of Health and Mantal Hygiene. In: If Item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0020

I is marked other than "natural", or items 23a or traumatic avant, the Madical Examiner must be a

Depentment of important: If it any injury or c

Physician

Avication

Examiner

4 Homicide 29a. Certifier (Check only one)

105 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and piace, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

war MD P-11710

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

AGNES HUSP, 900 CATON. AVE., BALTIMORE MD 21229 ROONEY IANOVICI, SHINT

31. Date filed (Month, Day, Year)

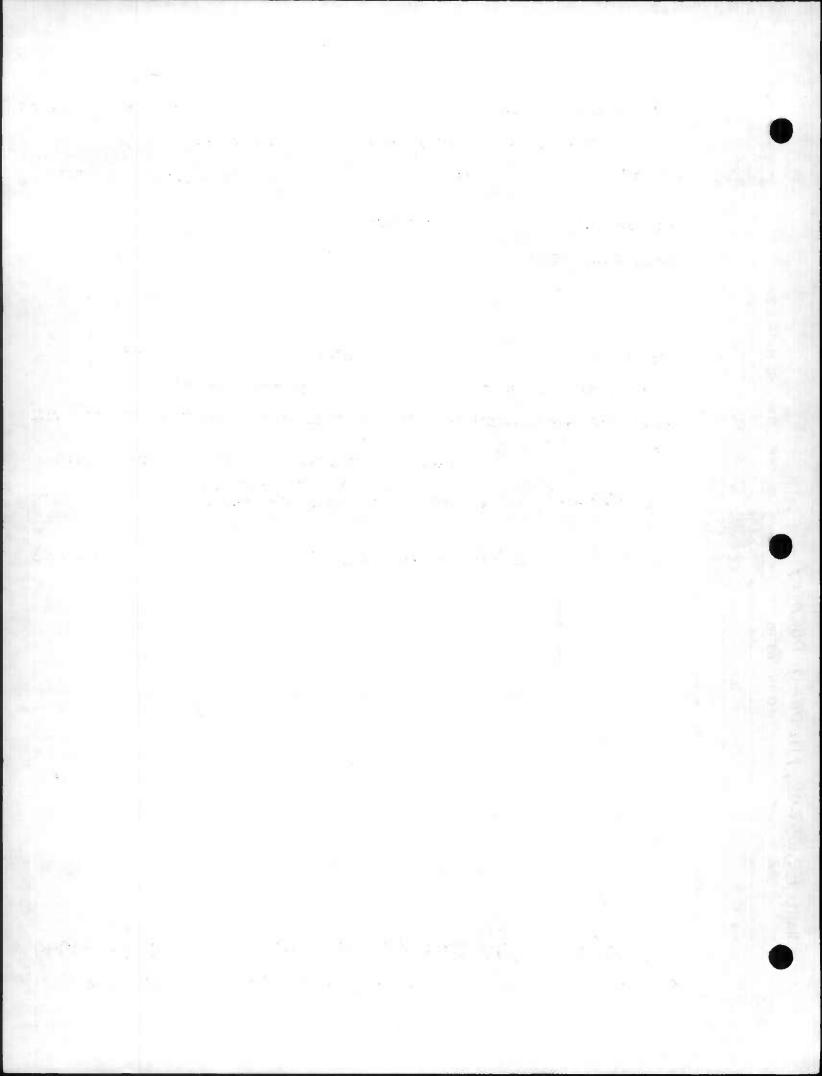
32. Registrar's Signature

29c. License number

State Registrar

DHMH 16 Rav 6/95

within 2 To the



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#10e,19b perFHG7682/23/99 EW 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death 18 1999 Yaar Month FEB **Physician** THEODORE ELFONT 8:50AM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death **Examiner** HOSPICE OF BALTIMORE GILCHRIST CENTER TOWSON BALTIMORE If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign 1905 **Funeral** Months Days Hours XXM 2□F MARYLAND 213-01-8709 93 Director Usual Rasidance of Decedant 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Expreises must be notified at 1 Yas 2 No Directo BALTIMORE 10e. Street and Number 10f. Zip Coda 10g, Citizan of What Country? 6807 PARK HTS. AVE. APT. 45 4J 21215 U.S.A. Funeral 13. Wes Dacedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Dacedant Evar in U,S. Armed Forcas? filed within 72 hours after 1 ☐ Yas 2 No If Yas, Giva 1 ☐ Navar Marriad 2 ☑ Married 1□ Yes 2录No Specify: Specify: WHITE by Yaar or Datas: 3 ☐ Widowad 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Hyglena. Elemantary/Secondary (0-12) College (1-4or 5+) RETAIL MERCHANT CLOTHING marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked other any injury or other traumatic event page. 17. Eather's Nama (First, Middla, Last) JONAS 18. Mothar's Nama (First, Middla, Maidan Sumama) Be ELFONT ANNA SEVEL 19b. Mailing Addrass (Street and Numbar or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 6807 PARK HTS. AVE. APT. 4J45 BALTIMORE MD 21215 ANN ELFONT/WIFE 20b. Place of Disposition (Nama of 20a. Method of Disposition 20c. Location - City or Town, Stata CHAIM 2/19/99 ANSHE EMUNAH -AITZ 1 Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) BALTIMORE MD CEMETERY 21. Signatura of Funaral Sarvice Licenses 22. Nama and Addrass of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Daath **Physician** /Medical Immediata Causa (Final prostate concer disaasa or condition resulting in daeth) Examiner Examiner Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated evants rasulting in daath) Last Dua to (or as a consaquance of): Box 68760 requires that the death certificate be Physician/Medical Dua to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by t d be datach 1 Ves 2 XNo 3 Probably 4 Unknown by 24b. Wara autopsy findings available prior to 24a. Was an autopsy performad? Completed peen complation of causa of death? page 2 1 Yas 2 No 1 ☐ Yas 2 ☐ No cartificate Attending Physician: director Be 25. Was case rafarred to madical 26. Plece of Death (Check only ona) axaminar? Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA this After this funeral of 27. Mannar of Deeth 28a. Data of injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Dascribe how Injury occurred 5 Pending Invastigation 1 Salatural 1 ☐ Yas 2 ☐ No death. 2 Accident Director: 6 Could not ba 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 4 Homlcida ò • Funeral Di e Funeral Di etely filled in 29a, Cartifian 1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, deta end place, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. Medical pietely (Check only one) within 2 To the 29d. Data signed (Month, Day, Year) 0 f person who completed cause of death (Itam 23a) (Type, Print) N. Chales St. Belfo GBMC 6201 2 32. Registrar's Signatura 31. Data filad (Month, Day, Year) FEB 2 3 State 1999

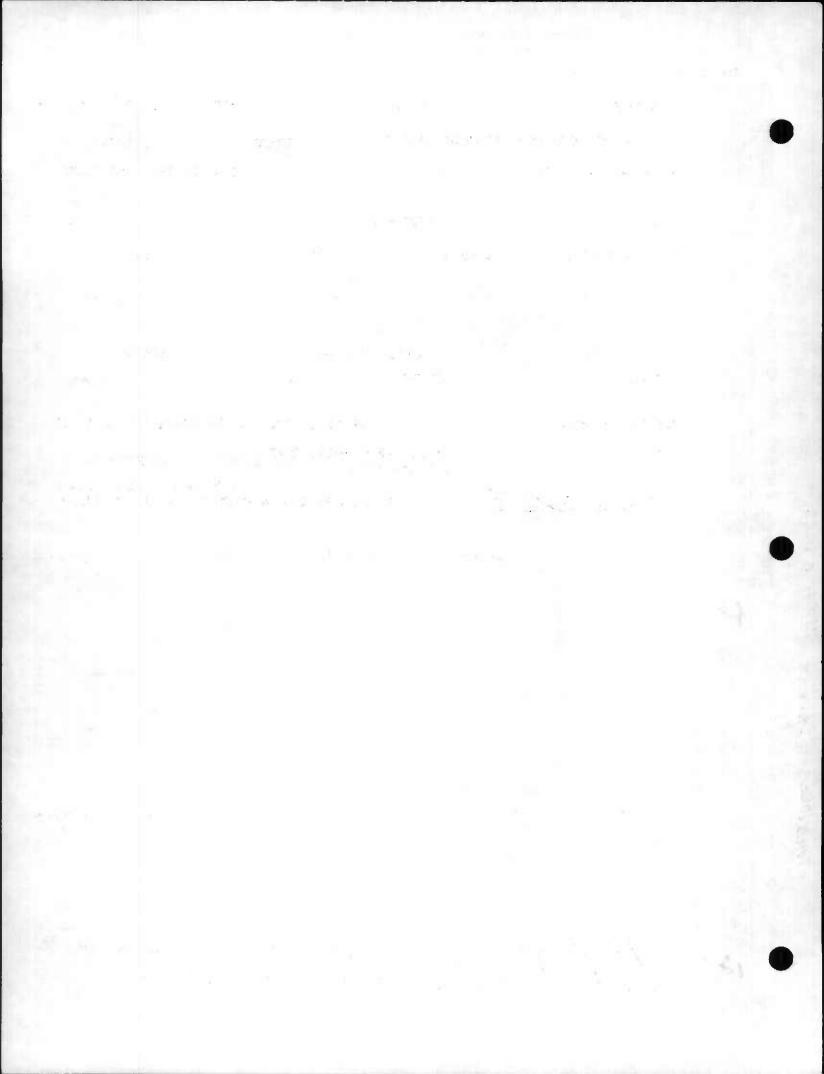
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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth D EB RUARY 20 1999 4e. Fecility Name (If not institution, give street 4b. City, Town, or Location of Deeth 4c. County of Deeth "LLAGE BALTO CARE CENTER Parkville 8. Dete of Birth - (Month, Dey, Year) 7 1913 If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthpiece (Stete or Foreign Country) 15 M 2□ F 85 216-44-2864 Maryland Usuel Residence of Decedent 10h Counts 10c. City, Town or Location 10d. Inside City Limits Baltimore Baltimore 1 ☐ Yes 2 X No Maryland 10a. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2030 Tred Avon Road 21221 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 17 Yes 2 No if Yes, Give Yeer or Dates: 1943-46 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Clerk Postal 12 years 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Michael John Amalia JoAnna Eisel 19e. informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 2030 Tred Avon Road Baltimore, Maryland 21221 Mary Eisel (sister) 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 2-23-99 Baltimore, Maryland Green Mount Crematory 22. Name end Address of Fecility Mitchell-Wiedefeld Home, Inc. 21. Signeture of Funeral Service Licensee geen 6500 York Road Baltimore, Maryland 21212 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Final (pase disease or condition resulting in deeth) Due to (or es e consequence of) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobaced use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24e. Wes en eutopsy performed? 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No 26. Plece of Beeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpetlent 3 DOA

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Director

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Be 2 10a. State

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show treumstic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after toppartment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iter any Injury or other treumatic event, the Medical Exercise.

Baltimore, Maryland 21215-0020

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attending physician and the 8 ed by the al signed by t should b page 2 certificate

Physician/Medical

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After this funeral or Attending death. efter death the f in by t To the Hospital o within 24 hours eff To the Funeral Di

P.O. Box 68760.

Division of Vital Records.

State Registra

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25. Wes case referred to medical 1 Yes 2 No 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigetion 1 Natural 1 Yes 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Madical Examiner: of the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.

| Madical Examiner: of the besis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature and title of cerutier

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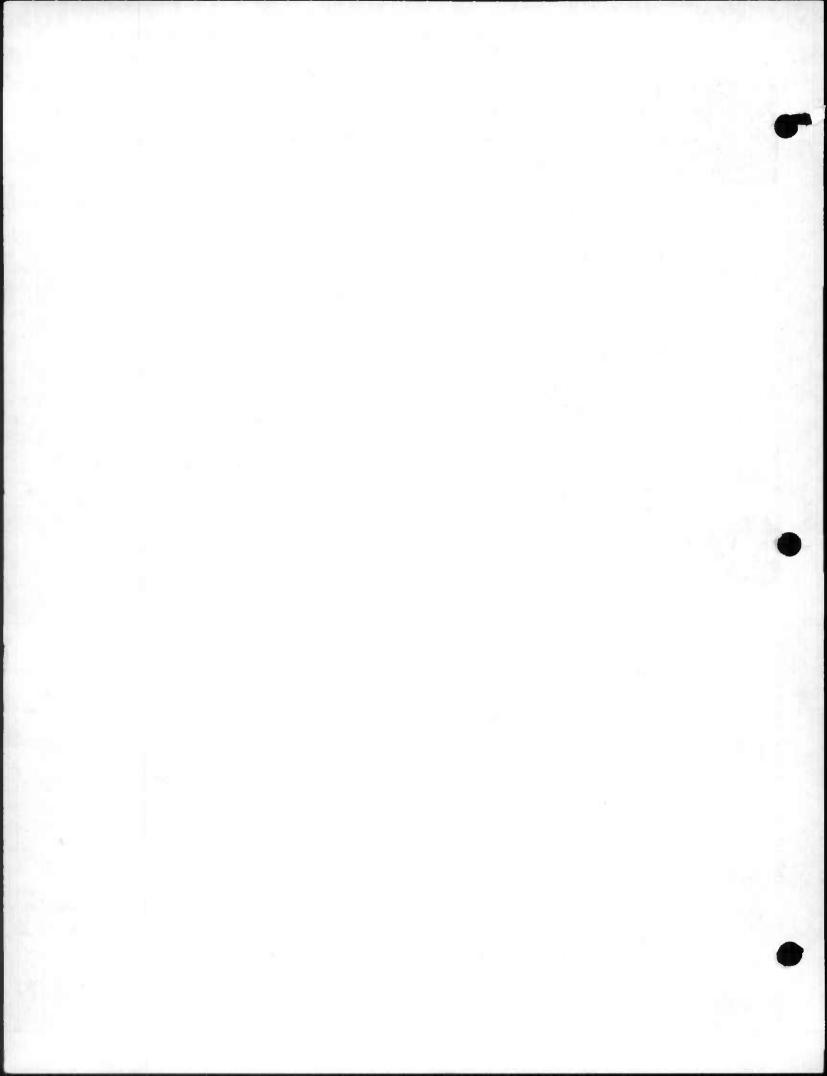
29c. License number

29d. Dete signed (Month, Dey, Year)

ad cause of deeth (Item 23e) (Type, Print) 1. Dete filed (Month, Dey, Year)

32. Registrer's Signeture

WALTHER BLVD. PARKYILLE

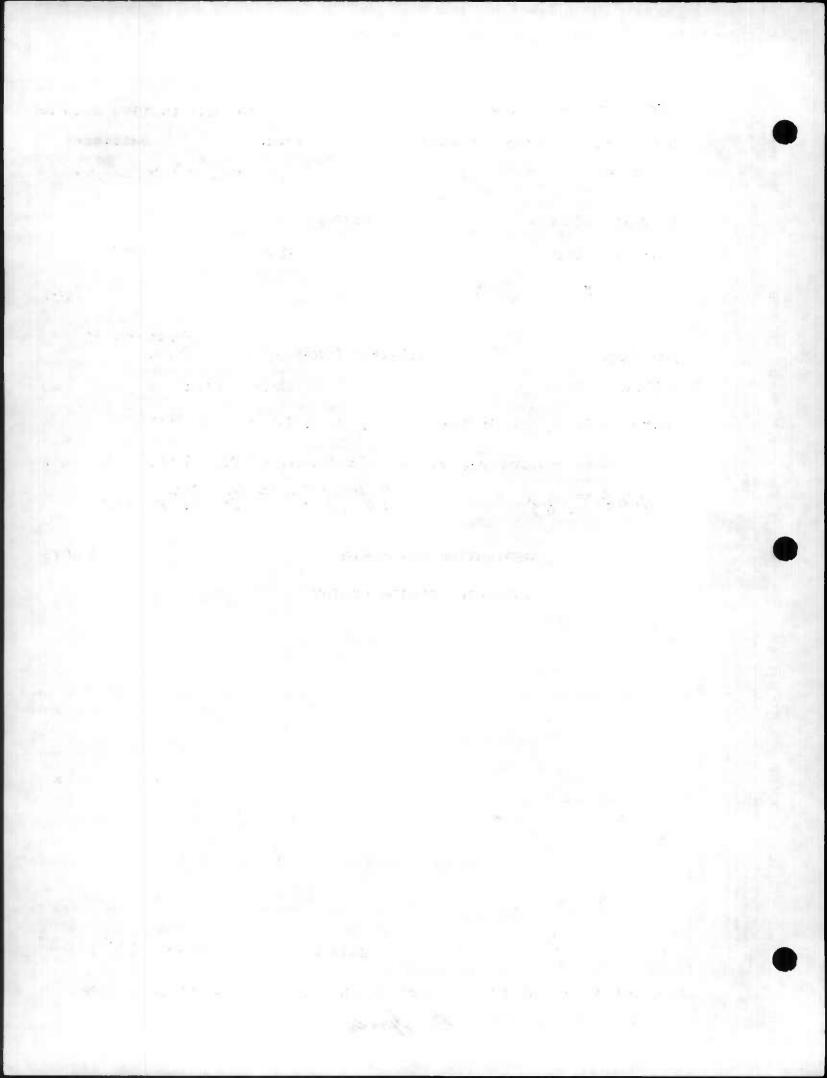


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Death Month **Physician** Christine D. FEBRUARY 19.1999 B: 45 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Saint Joseph Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2ØF Days 218-01-2594 78 Yrs. Feb. 22, 1920 Maryland Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show treumstic event, the Modical Examiner nast on norfied at 1 ☐ Yes 2 No Baltimore Director Maryland Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 26 Whips Lane 21236 U.S.A. Funeral 72 hours efter death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Department of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than eny Injury or other treumatic event, the Me 000s. Etementery/Secondary (0-12) College (1-4or 5+) Defense Background Investigator 12th Grade 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Browning William Bessie Bange 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Peges 1 and 2 Edward C. Ernst, Sr. (husband) 26 Whips Lane, Baltimore, MD 21236 20b. Ptaca of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dotner (Specify Entombrent Dulaney Valley Mausoleum 2/22/99 Timonium, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home, Inc. 23a. Part1. Enter the disease, scorint cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21236 Approximate Intervel Between Onset and Death **Physician** /Medicai Immediate Cause (Final disease or condition resulting in death) ASPIRATION PNEUMONIA 5 DAYS Examiner Due to (or es a consequence of) Physician/Medical Examiner ISCHEMIC CARDIOMYOPATHY hysician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 licate be physici Due to (or as a consequence of) that the death certif ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by d 1 Yes 2 No 3 Probably 4 Unknown by should s 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? page 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 No certificate Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 ■Inpatient 2 □ ER/Outpatient 3 □ DOA this After this 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of Injury 28c. tnjury et Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending hin 24 hours efter death. the Funeral Director: Af mpletely filled in by the fu 1 Tyes 2 □ No efter death. investigetion 2 Accident 6 Coutd not be determined 3 ☐ Suicide Location (Street end Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide Hospital 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end menner es steted. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. within 2 To the F 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 0 mulli mo D41410 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) JOGINDER P. M.D. 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 MEHTA. 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 2 3 1999

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Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1999 February 18 reingold ernard · /Medical Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** more (DIMAI Hospita If Under 1 Year 9 Birtholace /State or Foreign 7. Age (In yrs. lest birthday) 5. Sociel Security Number **Funeral** Months Deys Hours Min 1922 1**X** M 2□ F 216-16-3080 MARYLAND Yrs **Director** Usual Residence of Decedent with the Marylend 10b. County N/A 10a. Stete 10c City Town or Location BALT IMORE 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-1 show other treumstic event, the Madical Examiner must be notified at MD 1 Yes 2 □ No Director 10g. Citizen of Whet Country? 10f. Zip Code 21209 10e. Street and Number 5804 OLD PIMLICO ROAD permit. Peges 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mantal Hygiene. Important: if item 27 is merked other than "natural", or items 28s any injury or other treumetic event Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 Ø Yes 2 □ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, White, etc. WHITE 1 Never Married 2 Married 1 Yes 2 No altimore, Maryland 21215-0020 Specify: Specify. by 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade comp 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondery (212) College (1-4or 5+) MILITARY OFFICER U. S. ARMY 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be FEINGOLD MOLLIE SHARGEL **ABRAHAM JACOB** 19e. Informant's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 6804 OLD PIMLICO ROAD BALTIMORE MD 21209 THELMA FEINGOLD/WIFE 20b. Place of Disposition (Neme of BAP/PFMORPIONEERRY 2/21/99 REISTERSTOWN MD 20e. Method of Disposition 1 Buriel 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Se 22. Name and Address of Fecility SOL LEVINSON & BROS. INC. 21208 8900 REISTERSTOWN ROAD PIKESVILLE MD A SHOUND REISTERSTOWN ROAD PIRES The property of control of the c Approximete Interval Between Onset and Death **Physician** Immediate Ceuse (Final diseese or condition resulting In deeth) /Medical DSIS Examiner Physician/Medical Examiner Acute Respiratory Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): 88 neumonia 980 23b. Did tobacco use contributa to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. the signed by t 2 XNo 3 Probably 4 Unknown 1 Yes arcinoma à 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed peeu page 2 hes 20 No 1 Yes 1 Yes certificate or Attanding Physicien: funeral director, 25. Wes case referred to medical exeminer? 28. Piece of Deeth (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P Impatient 2 ☐ ER/Outpetient 3 ☐ DOA After this 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of Certification: 28e. Dete of Injury (Month, Day 28c. fnjury et Work? 1. Avatural 2 Accident 5 Pending 1 Yes 2 No death. investigation 24 hours efter deat Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, fectory, office bullding, etc. (Specify) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner as steted. Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner steted. 29a. Certifier Medical completely (Check only one) within 2 To the 29b. Signature and tipe of certifi 29d. Date signed (Month, Dey, Year)

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State Registrar 30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print)

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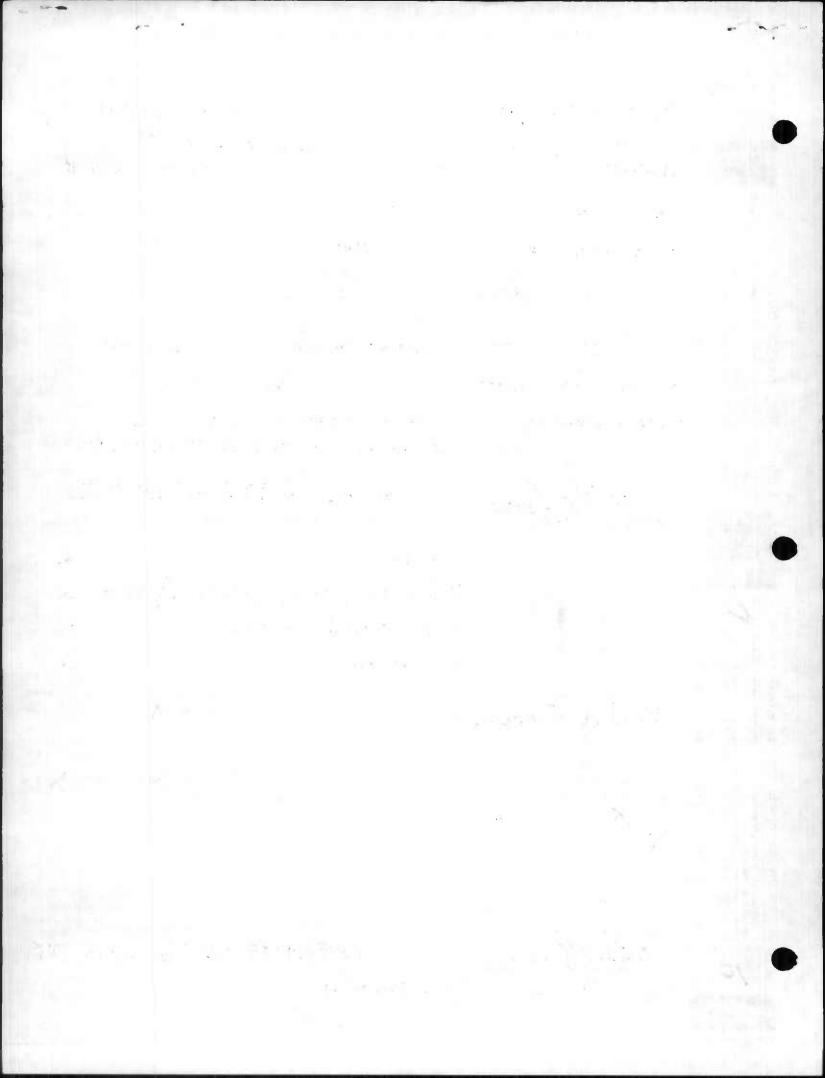
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32. Registra s Signeture

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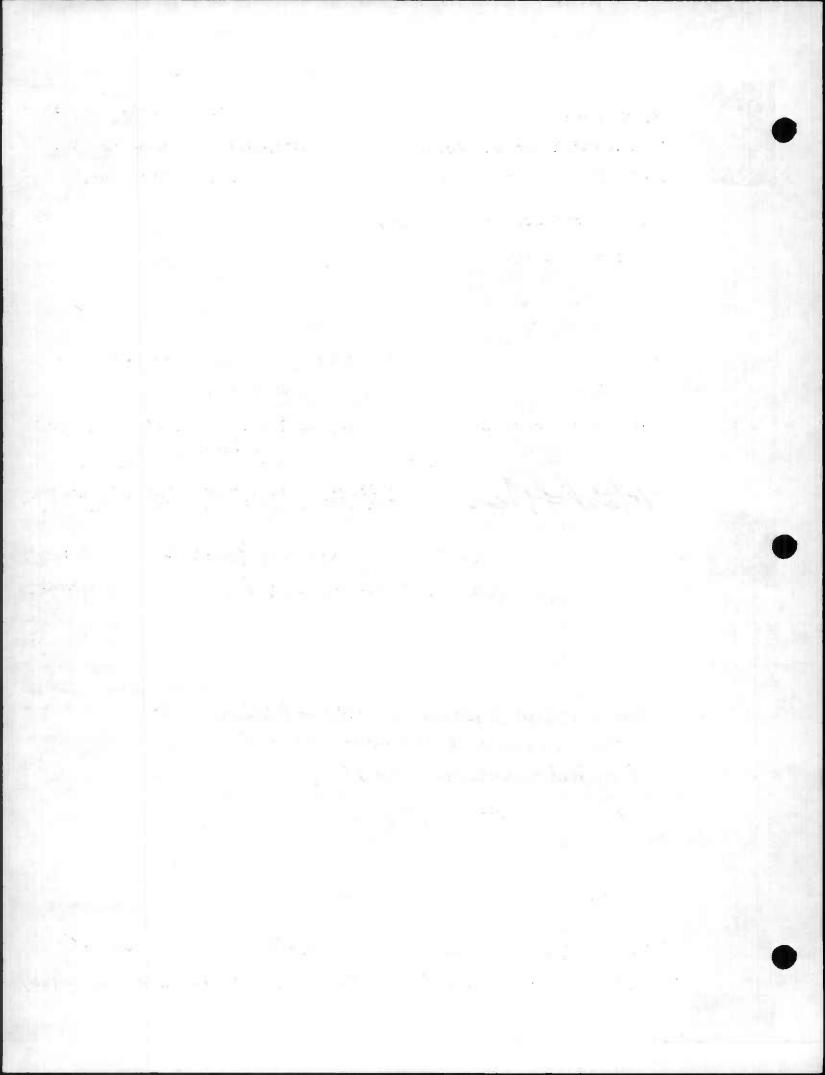
Certificate of Death 2. Data of Daath 1. Decedant's Nama (First, Middla, Last) 3. Time of Death **Physician** Feb 21, 1999 4c. County of Death 25 P. Mary H. Foust 4a Facility Nama (If not institution, give street and number) * /Medical 4b. City, Town, or Location of Deeth Examiner Anne Arundel General HOSD (In yrs. last birthday) Annapolis Anne Arundel

9. Birthplaca (Stata or Foreign
Country) 8. Data of Birth (Month, Day, Year) If Under 1 Yaar **Funeral** 1 M 2 F Months Days Hours Min. Yrs. Director 209-10-2775 Usuei Rasidence of Dacedant Mar. 1, 1917 Pa-10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, it a Madical Examinar must be notified at 1 Yas 25No Director Md. Anne Arundel Annapolis 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Coda 1413 Bay Head Road Funeral 21401 U SA Race - American Indian, 12. Was Dacedent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Orlgin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Fican, atc.) 11. Maritei Status permit. Peges 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural", or item any Injury or other traumatic event, the Medical Exercises once. Black, White, etc. 1 Yas 2 No If Yas, Give Year or Datas: 1 ☐ Navar Marriad 2 ☑ Married altimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify þ 3 Widowad 4 Divorced White Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b, Kind of Businass/Industry Elamentary/Secondary (0-12) Coilega (1-4or 5+) Own Home Homemaker 18. Mothar's Nama (First, Middla, Maidan Sumame) 17. Fether's Nama (First, Middle, Last) Be John Holub Anie Span 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Tracy Foust/ Husband 1413 Bay Head Rd., Annapolis, Md. 21401

20b. Place of Disposition (Nama of camatary, cramatory or other place)

Data
2-23-99 20a. Mathod of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Ramoval from Steta 4 ☐ Donation 5 ☐ Other (Specify) Balto- Wash. Crematory Laurel, Md. 22. Name and Addrass of Fecility Bradley-Ashton-Matthews Funeral Home, In 2134 Willow Spring Rd., Balto., Md. 21222 Approximate shock, or heart failure. List only one cause on each line. Intarval Betwaan Onset and Death **Physician** /Medical immediata Causa (Final disaasa or condition rasulting in daath) failure Examiner Examiner 2171 CAL BURG ician and burial-trans Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaase or Injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the Due to (or es e consequence of): 80 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? DIASULS Melle 1 Yes 2 No 3 Probably 4 Unknown Non-cusulus depundent Division of Vital Records, p mic os shueline pulnum dis inde 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death? Completed Dilatel condit myo par t 1 Yas 20 No or Attending Physician: 25. Was casa rafarred to medical axaminar? Be 26. Placa of Daath (Check only ona) 1 Yas 2 No Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 2 28a. Data of injury (Month, Day Yaar) 27. Mannar of Death 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Time of Certification: 1 Naturai 2 Accidant 5 Panding after deeth. 1 ☐ Yas 2 ☐ No Invastigation Could not ba datarmined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At home, farm, streat, factory, office building, atc. (Spacify) 4 Homicida 24 hours a Funeral C Hospital Certifying Physician: To the bast of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.

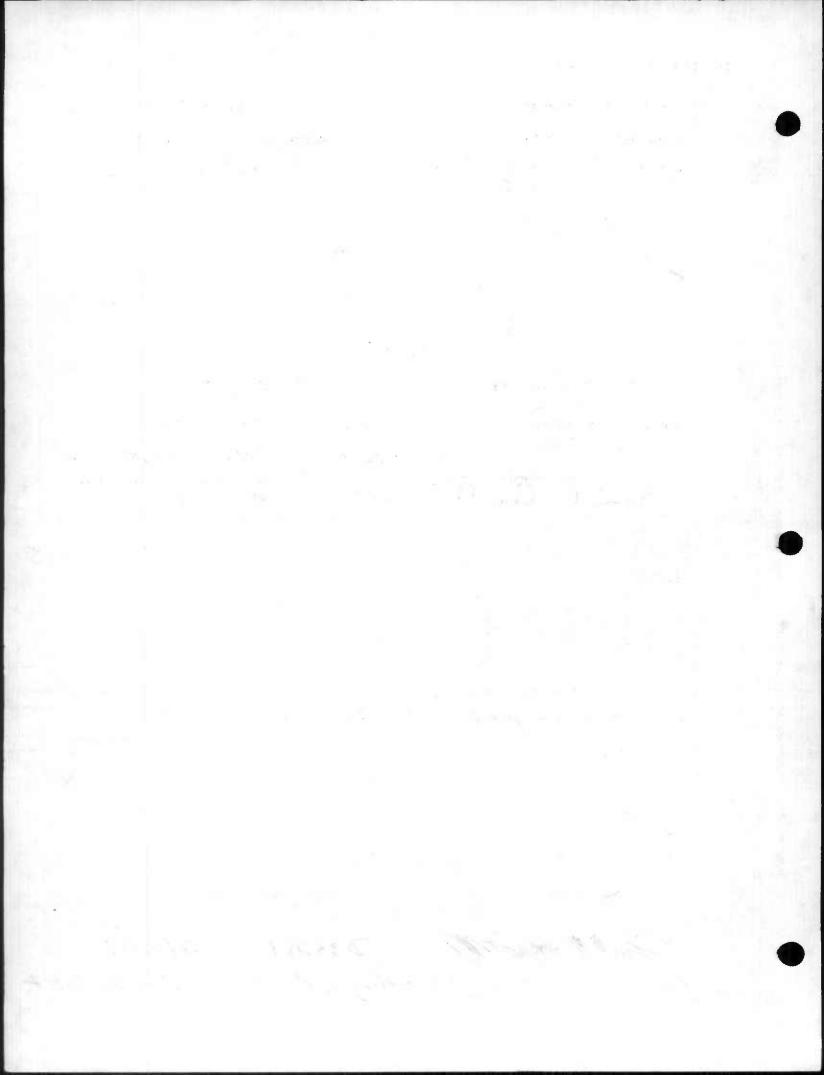
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and menner stated. 29a. Cartifian Medical (Check only one) within 2 To the 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifie 30. Nama and offices of person who complated causa of daath (Item 23a) (Type, Print) Ridgely Au Annapales 32. Registrar's Signatura Month, Day, Year) State FEB 2 Registrar



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/Medical	-	4a. Fecility Neme (If not institution, g		ber)				4b. City, Town, or I	February Location of Deeth		99 of Deeth	9:35 PM		
LAMIIIIE		Westminster Nursing						Westminster	•	Carrol				
Funerai Director		218-40-8953	Sex 1 □ M 2ĐXF		lest birthday) 3 Yrs.	If Under Months	Year Deys	If Under 24 Hrs. Hours Min.	8. Dete of Birt (Month, De) May 26, 1	h, Year) 905	9. Birthi Cou MD	placa (Stete or Forai ntry)		
r tems 23a or 28a-f show the must be notified at Funeral Director	-	Usual Residence of Decedent 10e. Stete 10b. County		10c. Cir	ty, Town or Lo	cation					1	10d. Inside City Limit		
	2	MD. Carroll		Wes	tminster							1 ☐ Yas 2X N		
	al Dire	10e. Street and Number 1234 Washington Road					21157 10g. Citizen of V USA					ntry?		
o, a	2	11. Marital Status 1 Naver Merried 2 Marriad 3 Widowed 4 Divorced	12. Wes Decade Armed Force 1 Yes 2 If Yes, Give Yaar or Date	No No		Vas Decede Yes, speci Yes 2		lispenic Origin? (S an, Mexican, Puert Specify:	pecify Yas or No- o Rican, etc.)	Specify	k, White,			
than "natural", the Medical Exe	Be Completed	ompleted	Completed	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12)	Education rada completed) College (1-4	lor 5+)	16a. Deced (Give life. L Homema		Occup done retire	eation during most of world)	king	16b. Kind of Br		dustry
ovent, Be Co		17. Fathar's Name (First, Middle, Las			Talala	illo		18. Mother's Nan	ne (First, Middle,					
		Bernard Frederick	-Day DEY					Lydia Je	ennie Pear	ræ				
5 00 2		19e. Intorment's Name/Reletionship						end Number or Ru			Stete, Zip	Code)		
om 2	1	Mark E. Gardner (gr 20e. Method of Disposition	randson)	20b. F	1400 M Pleca of Dispos cemetery, crem	t. Cam		Rd. Park	ton, MD.	21120 20c. Location -	City or To	own, Stata		
nt: If I		1 Buriel 2 Cremation 3 4 Donetion 5 Other (Spec			ltop Ser			ca)	2/22/99	Towson,	VAT-			
Important: If its any injury or o		21. Shouture of Funaral Service Lice	Dennis C	Carpro	11	Neme and			ick Towson		Home,	Inc.		
ysician ledical aminer		Enter the disaasa, or con shock, or heert teilure. List only immadiata Ceuse (Final diseese or condition resulting in deeth)	6	Se	P5/	5					1	Approximate Intervel Between Onset and Deeth		
nding physician and use as the buriel-transit		Sequentielly list conditions, if eny, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest	c		r as e consaqu			17.3 11.4						
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cate hes page 2									1□ Y	as 2 No	1[Yas 20 No		
director, pag		25. Wes case reterred to medical exeminar? 1 □ Yes 25√No	Hospitel:				Oth	26. Plece of Dee						
funeral funeral		7. Menner of Deeth 1. Naturei 5 Pending 2 Accident Investigation	n	-	ER/Outpetient 28b. Time of injury		c. Injur Wor	40 Nursing H	ome 5 ☐ Resid 28d. Describe h			ýy)		
		3 ☐ Sulcide 6 ☐ Could not to determined	building,	etc. (Specify					City or Tow	n, Stete)		of Route Number,		
he Fune pletely fil edical	1	29e. Certifier Check only one) Certifying Pl	nysicien: To the be minar: On the basis end menner	s of exeminal	wledge, deeth tion end/or inv	occurred et estigetion, i	the tin	ne, dete end place, pinion, deeth occur	end due to the c red et the time, c	euse(s) end me lata and place, o	nner as s	tated. the cause(s)		
To the		9b. Signeture and title of certifier	Agnot	411	,	29c.		a number 3 28 /	2	9d. Data signad	(Month,	Dey, Year)		
	3	0. Name end eddress of person who	completed cause of	of deeth (Item	23a) (Type, F	Print)	1		Wester	- ///	111	121159		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Gibison 10:390 Radiance 18,1999 Feb /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Maryland Medica Center Baltimo of Baltimore University 8. Date of Birth (Month, Dey, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days 1□ M 28 F Yrs. Director 68 May 14, Md. 218-26-4068 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryfan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Innuy or other traumatte event, the Marical Exercise mant to notified at any Innuy or other traumatte event, the Marical Exercise mant to notified at 1 ☐ Yes 2K No Director Md. Baltimore Towson 10e Street and Number 10q. Citizen of What Country? 10f. Zip Code 3 Southerly Ct Funeral IISA 21286 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U,S Armed Forces? 14. Raca - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🕅 Married Baltimore, Maryland 21215-0020 1 Yes 25tNo Specify: Specify. à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 John C. Byrnes Geiselman 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. George Gibison/husband 3 Southerlt Ct. Towson, Md. 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 2/22/99 Overlea, Md. Gardens of Faith 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 25 1050 York Rd. Towson, Md. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** /Medical Immediate Cause (Final cerebrovascular accident disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or es e consequence of): physicien s the buriel Box 68760 Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. ed by the a 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. ed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown þ Sign The 24b. Were autopsy findings available prior to completion of cause of death? should I Completed 24a. Was an autopsy performed? page 2 has 2) No 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific funeral director, 25. Was case referred to medicat examiner? Be 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Depatient 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one)

State Registrar

5

29b. Signature and title of certifier

KATRINA 31. Date filed (Month,

allina

MURPHY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22 S. Greene 19992. Registry Signature

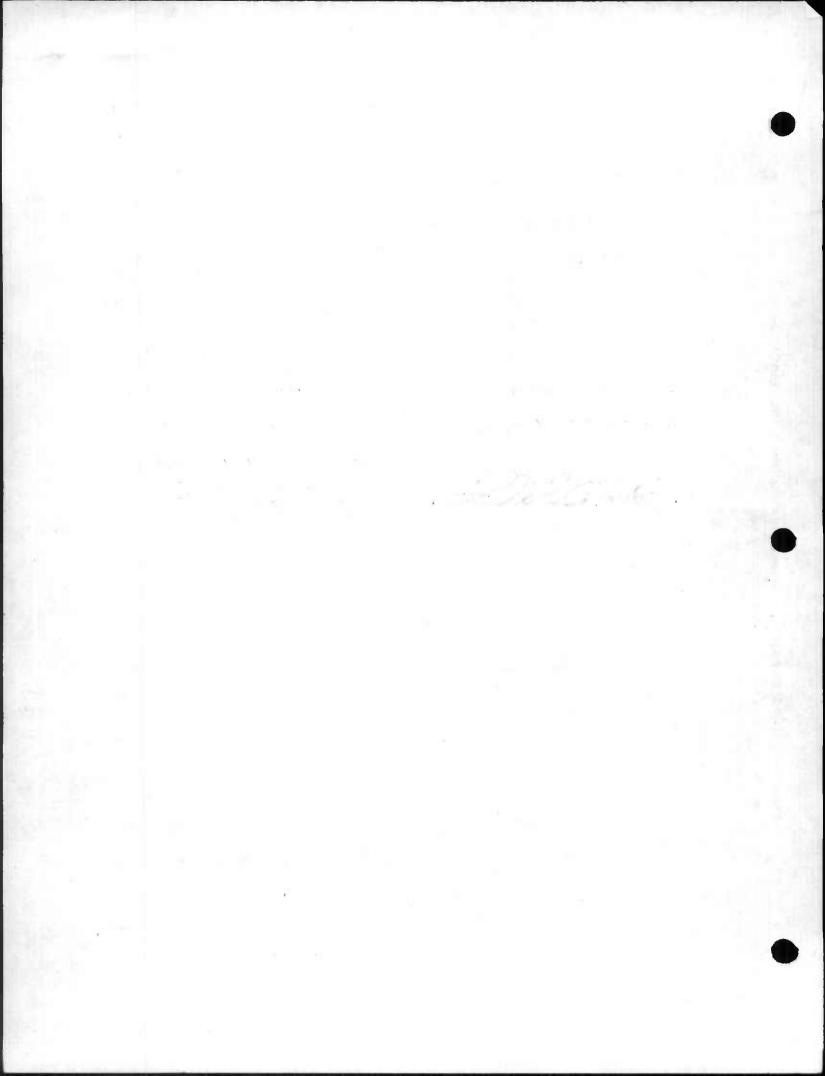
DHMH 16 Rev 6/95

ESIDENT

29c. License number

Baltimore, MD 21201

29d. Date signed (Month, Day, Year)



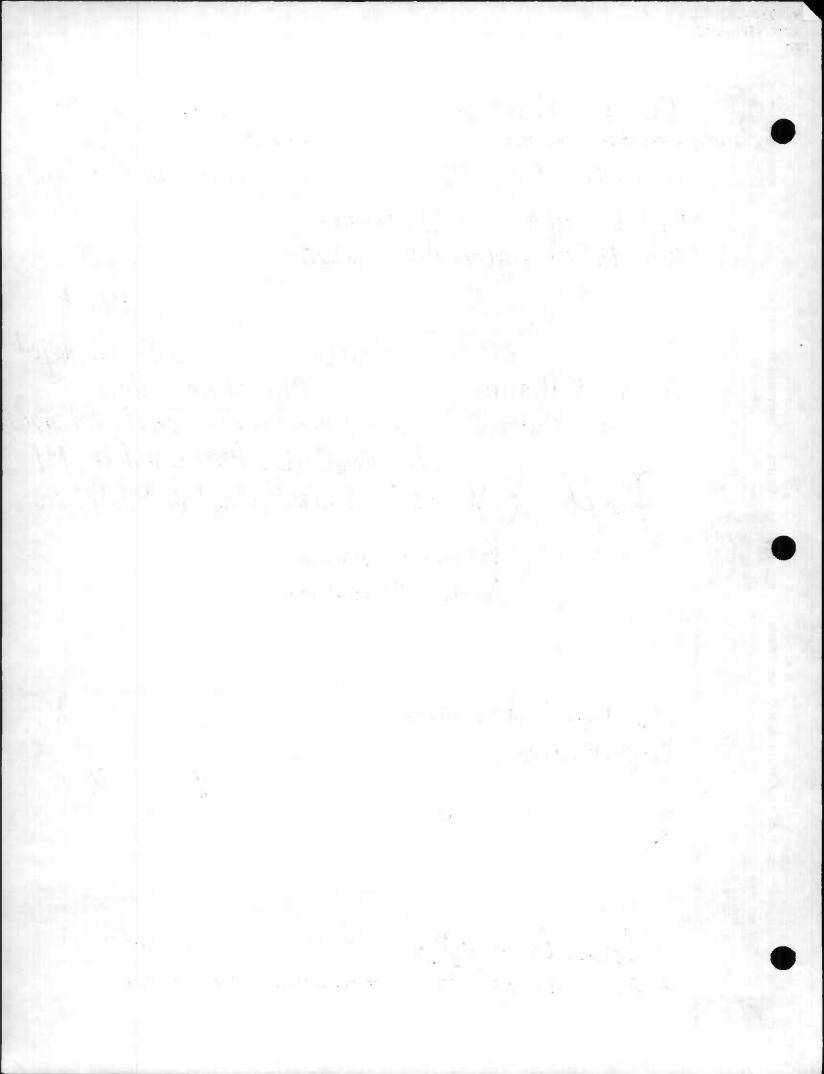
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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Daeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month **Physician** 0542 AM 18, 1999 FEBRUARY /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deel Examine JOHNS HOPKINS HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) Deys 216-78-2943 Usuel Residence of Decedent 1 M 2 F Yrs Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health end Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Directo more 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene.
Important: If Item 27 is marked other then *natural', or items 23a or any injury or other traumatic event, it a Wedness Evantine from the items. 8 2 Funeral d . Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian Bleck, White, etc. 11. Marital Stetus 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced a Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use refired) 16b. Kind of Business/Industry Elemantapy/Secondary (0-12) Collette (1-4or 5+) 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Surnam Be am 19b. Mailing Addrass_(Streat end Number aloria Place of Disposition cametery, cremetory 20e. Method of Disposition 20c. Location 1 XBurial 2 ☐ Cremetion 3 ☐ Removel from State 4 Donetion 5 DOther (Specify) arden 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Joseph WINDS .21216 Enter the disease, or complication that caused the deeth. Do not entar the mode of dying, such as cerdiac or responser that are. List only one cause on each line. Approximate Intervel Between Onset end Daeth **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical **Examiner** Physician/Medical Examiner attending physician end for use es the bunel-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate ceusa. Enter Undarlying Causa (Disaasa or Injury that Initieted events resulting in deeth) Lest Due to (or es e consaguance of) P.O. Box 68760. Due to (or es e consequence of). 65 Pert II. Other algniffcant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Dfd tobacco use contribute to the cause of death? 4 Unknown signed by t 1 Yes 2 No 3 Probably Division of Vital Records, by 24b. Were eutopsy findings available prior to completion of cause of deeth? been si 24e. Wes en eutopsy performed? Completed certificate hes b lirector, page 2 s 2 No 2 No Yes or Attending Physician: Be 25. Was case referred to medice 26. Place of Death (Chack only one) Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) Certification: To XX Yes 2 □ No 1 Inpatiant XXXER/Outpatiant 3 DOA After this funeral Dete of Injury (Month, Dey Yeer) 27. Mannar of Daath Neturel 2 Accident 28c. Injury et Work? 28d. Describe how Injury occurred 5 Panding investigation 2 No 24 hours efter death. 1 Yes 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicide Hospital 29a. Certific 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and mennar as stated completely Medicel Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and dua to the causa(s) end menner stated. To the F within 2 29c. License number 29d. Date signed (Month, Day, Year) FEBRUARY 18, 1999 O.C.M.E. ath (Itam 23e) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 31 Date filed /Month. Day. Year) State Registra



Box 68760 OLDSTEIR

Physician

· /Medical

Examiner

Director

Funeral

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Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic avent, the Medical Examiner must be notified at

2 should be filled within 72 hours efter nend Mentel Hygiene. Is merked other than "natural", or fter

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any Injury or permit. Page Department of Important: If

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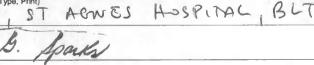
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Medical 29b. Signature end title of cartifier 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) MUTOMBO

31. Dete filed (Month, Day, Yeer)

FEB 23

KANKONDE 32. Registrer's Signeture Much



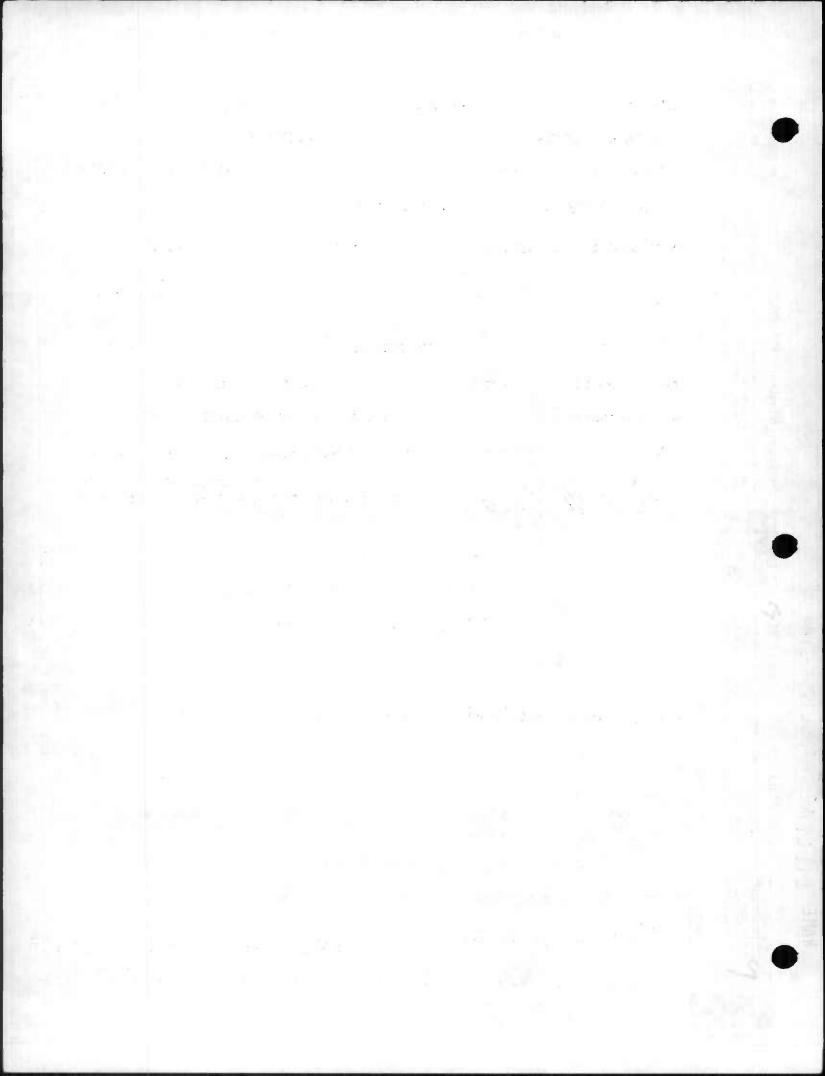
29c. License number

D46704

29d. Date signed (Month, Day, Year)

Registrar **DHMH 16 Rev 6/95**

State



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day Month Yeer **Physician GORDON** SONYA RITA 1999 February 16 2:15pm · /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Sinai Hospital of Baltimore Baltimore If Under 24 Hrs. 9. Birthplece (State or Foreign If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth Fibrath, Day, 19935 6. Sex **Funeral** Deys Months Hours 1 M 2 XF 64 Yrs. MARYL AND 213-32-3341 Director Usual Residence of Decedent the Marylenc 10c. City, Town or Location 10d. Inside City Limits 10a Stete 10b County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No PARKTON BALTIMORE Director 10e. Street end Number 10f. Zip Code 21120 10g. Citizen of Whet Country? 7 BENTLEY ROAD Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14 Race - American Indien. 11. Merital Status Bleck, White, etc. 1 Never Married 2 Married SpecifyWHITE If Yes, Give Year or Dates: 1 ☐ Yes XX No Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) al Hygiena. College (1-4055+) Etementary/Secondery (0-12) ROOFING CO. PRESIDENT 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be should be f WEINSTEIN **EDWARD** FLITMAN and Mental DOROTHY 10 19a. Intormant's Name/Retetionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 end 2 st Depertment of Heelth and Important: If Item 27 ie m any Injury or other traun 5704 CEDAR LANE COLUMBIA MD 21044 DEBORAH GORDON /DAUGHTER 20b. Place of Disposition (Neme of ANSHE EMUNAH —AITZ CHAIM 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 2/18/99 BALTIMORE 4 Donetion 5 Other (Specify) CONGREGATION CEMETERY 21. Signature of Eigheral Service Licensee 22. Name end Address of Fecility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE MD 21208 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical Ischemiz Bowel 7 years Examiner Due to (or es a consequence of): Examiner Metastatic Squamous Cell Carcinoma 7 months physician and s the burial-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or es e consequence of): 80 usa signed by the a id be detached f 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown of Vital Records. been signe should be P 24b. Were eutopsy findings evaileble prior to completion of ceuse of deeth? 24a. Wes en eutopsy Completed performed? pege 2 2 N No 1 ☐ Yes 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medicat 26. Plece of Deeth (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpetient 3 DOA this 27. Manner of Deeth 28d. Describe how injury occurred 28c. Injury at Work? Certification: I or Attending P after deeth.

Director: After to d in by the funera Division 1 Naturel 5 Pending Investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 - Homicide Hospital 24 hours a Funeral C Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner es stated.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) end manner estated. edical 29a. Certifier To the within 2 29b. Signature and 29d. Date signed (Month. Dev. Year. 29c. License number P12309 February 16, 1999 10 30. Name and eddress of person who o inpleted ceuse of deeth (Item 23a) (Type, Print) Michael E. Bunkel, MD 32. Registrer's Signature Sinai Hospital of Baltimore, 2401 W. Belvedere Ave. 31. Dete filed (Month, Dey, Yeer) FEB 2 3 State 1999

DHMH 16 Rev 6/95

Registrar

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Patient Known

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Neme (First, Middla, Last) 2. Date of Death John B. Griffith February 15 1999

7. Age (In yrs. last birthday)

64

12. Wes Decedent Ever in U,S. Armed Forcas?

College (1-4or 5+)

1 Ryas 2 No If Yes, Give Year or Dates: 1957-59

Yrs.

10c. City, Town or Location

Shady Side

Captain

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodfield Cemetery

4b. City. Town, or Location of Death

8. Date of Birth (Month, Day, Year)

18. Mother's Name (First, Middle, Maiden Surname)

Date

Alice Nichols

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1123 Steamboat Road, Shady Side, MD 20764

Annapolis

If Under 1 Year | If Under 24 Hrs.

Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.)

Days

10f. Zip Code

20764

1 ☐ Yes 2 No Specify:

Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired)

3. Time of Death

3:21 pm

10d. Inside City Limits

1 ☐ Yes 2 No

Birthplace (State or Foreign Country)

4c. County of Death

10g. Citizen of What Country?

USA

Anne Arundel

13, 1934 Washington, DC

14. Race - American Indien, Bleck, White, etc.

Anne Arundel Co. Fire Deot.

Specify: White

16b. Kind of Business/Industry

20c. Location - City or Town, State

2/18/99 Galesville, MD

Physician /Medical Examiner

Funeral

4a Facility Name (If not institution, give street end number)

5. Social Security Number

577-44-4241

Usuel Residence of Decedent

Anne Arundel Medical Center

6. Sax

XXM 2 F

Director 28a-f show 6 Nems 23s natural', or Hygiene.

filed within 72 hours after Saltimore, Maryland 21215-0020 permit. Peges 1 and 2 should be flik Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event once.

Physician /Medical Examiner

physician and s the burial-transit Box 68760 P.O. signed by the Records, Division of Vital or Attanding Physician: this After death.

after death Director: in 24 hour. The Funeral Direction of the filled in by To the Hosp within 24 hor To the Fune completely fi

12 Be Examiner Physician/Medical à Completed Be Certification: To 1 Neturel 2 Accident 3 ☐ Suicide 4 ☐ Homicide 29a. Certifier Medical (Check only one)

10a. State 10b. County MD Director Anne Arundel 10e. Street and Number 1123 Steamboat Road Funeral 1 ☐ Nevar Married 2 ☑ Merried 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) 17. Fether's Neme (First, Middle, Last) Ward Wilson Griffith 19e. Informant's Neme/Reletionship (Type, Print) Ginger M. Griffith - Wife 20a. Method of Disposition Burial 2 Crametion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Eugeral Service Licens alac Immediata Ceusa (Final diseese or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Dissess or Injury that initiated events resulting in death) Last 25. Wes case referred to medical exeminer? 1 Yes 2 No 27, Manner of Death 5 Pending investigation

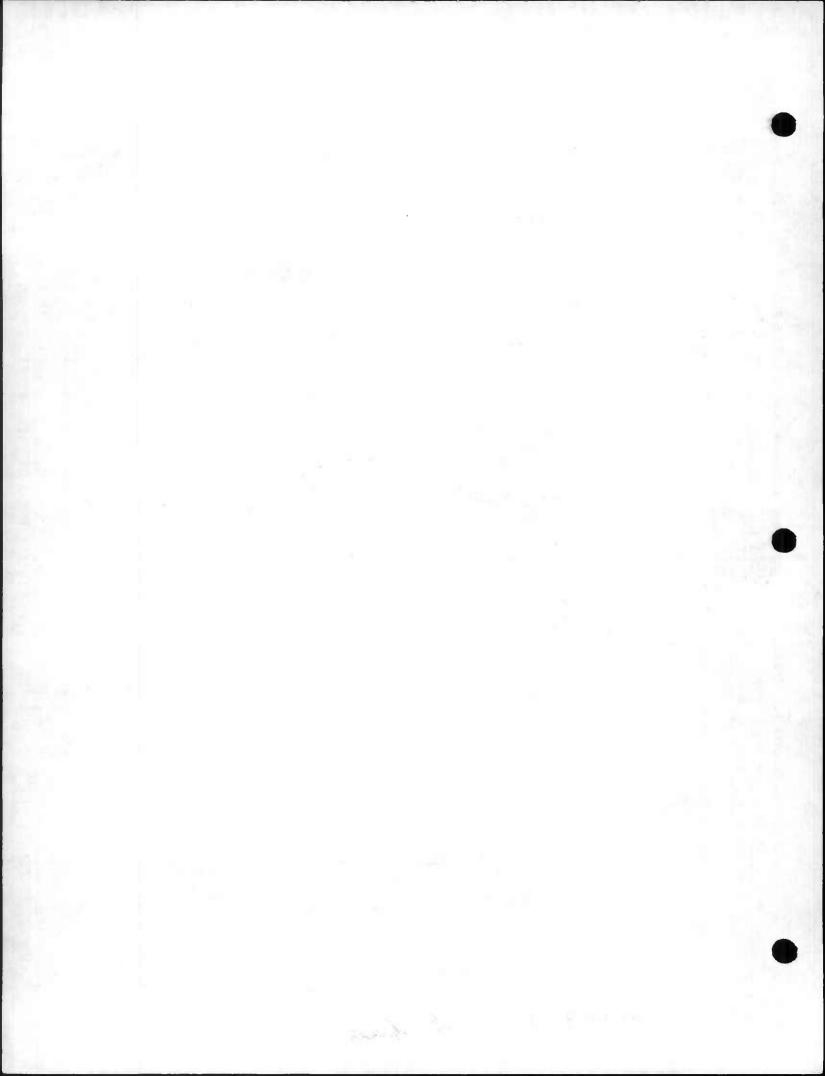
JAmes 31. Data filed (Month, Dey, Year) FEB 2 3 1999 State Registrar **DHMH 16 Rev 6/95**

29b. Signature and title of certified

Kuppel 32. Regisfrar's Signetura

6 Could not be determined

22. Neme and Address of Fecility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximata Intervat Between Onset and Death liphlastoma Due to (or es a consequence of) Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24e. Wes en autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 1 TYes 2 □ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted. 29c. License number 29d. Date signed (Month, Day, Year) 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Dr , mD 21401 Spark **ORIGINAL**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#11 perFHG770 4/6/99 EW 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month WiNNIF REd Godwin 4a. Facility Name (If not institution, giva straet and number, 4b. City, Town, or Location of Death 4c. County of Death Valley Narsing + Lehab WalkersvillE Glade FREderick 7. Aga (In rs. lest birthday) If Under 1 Yaar | If Undar 24 Hrs. 5. Sociel Security Number 6. Sex Birthplaca (Stata or Foreign Country) 1 M 2 F Months Deys 212-12-1323 Maryland Usual Rasidanca of Decedant 10b. County 10c. City, Town or Location 10d. Insida City Limits N/A Maryland Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizan of Whet Country? 1319 East Patapsco Avenue 21225 U.S. 12. Was Decedent Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Maxican, Puerto Rican, atc.) Race - American Indian, Black, Whita, atc. 1 ☐ Yas 2 ☑ No If Yes, Giva Yeer or Datas: 1 Navar Married 2 Married Specify: 3XX Widowed ◆ Divorced White 15. Dacedant's Education (Specify only highast grade completed) 16a. Decadant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12th Homemaker Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Edward Huell Thompson Nora Belle Willoughby 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Samuel Godwin III son 164 K Hammarlee Road Glen Burnie, Maryland 21060 20b. Piace of Disposition (Nama of cematary, cramatory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Steta Dete 1 Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 2/20/99 Baltimore, Maryland Woodlawn Memorial Park 4 □ Donetion 5 □ Other (Specify) 22. Nama and Addrass of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 ramerouse on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, any one cause on each line. Approximata Interval Batween Onsat and Daath Immediata Causa (Finel CONGESTIVE HEART FAILURG 1 Hour diseasa or condition rasulting in deeth) CARDIOMYO PATH Due to (or as a consaquance of) Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings evailabla prior to complation of cause of daath? 24a. Was an autopsy

Physician /Medicai Examiner

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Hospital of 24 hours a Funeral D

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Division of Vital Records, P.O.

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10a Stata

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mexical Examiner mant be notified at

permit. Peges 1 end 2 should be filed within 72 hours after. Department of Health end Mental Hygiene. Important: If them 27 is merked other than "natural", or ites any Injury or other traumatic event

3altimore, Maryland 21215-0020

with the Maryland

death

Sequantially list conditions, if eny, laading to immadiata cause. Entar Undarlying Causa (Disaasa or Injury that initiatad evants rasulting in daath) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hyper tension

25. Was casa rafarrad to madical axaminer? 26. Placa of Daath (Check only one)

200 No 1 🗆 Yas 1 ☐ Yes 2 No

1 Yas 2 No 27. Mannar of Death Hospital: 1 Natural 5 Panding invastigation 2 Accident

Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 1 Yas 2 No

801

28d. Dascribe how injury occurred 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifian (Check only one)

3 Suicida

4 Homicide

1 Certifying Physician: To the bast of my knowledge, deeth occurred at tha tima, data and placa, end dua to the cause(s) and mannar as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and place, end due to the cause(s) and mannar stated.

29b. Signatura end titla of cartifiar

6 Could not be datarmined

29c. Licansa number D43091

29d. Data signed (Month, Day, Yaar)

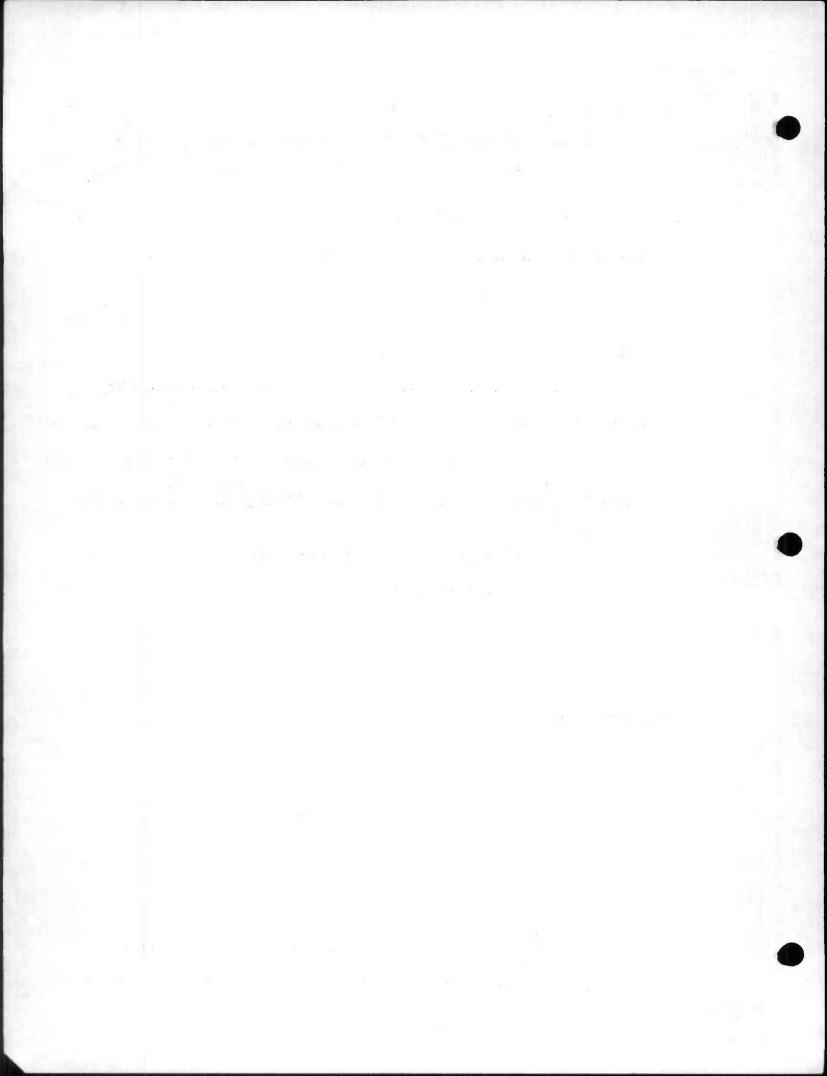
30. Name and eddress of parson who completed causa of daath (Item 23a) (Type, Print)

28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

SAEED

MD CAIDI 82. Ragistrar's Signature TOLL HOUSE AVE, FREDERICK

State Registrar



Funeral

Director

r than "natural", or items 23a or

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Funeral

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Completed

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Examiner

Physician/Medicai

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Certification:

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Division of Vital

other traumetic event.

altimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

rtificate of Death	Reg. No.	603
	2. Date of Death	3. Time of Death
hon	FEB. 08, 1999	10:41 PM.

	1.	Decedent's Name (First, Middle, Last)
Physician /Medical		Larry
Examiner	4e	Fecility Name (If not institution, give street and nut
		HARBOR HOSPITAL

FEB. 08, 1999 Wayne Gollahon 4b. City, Town, or Location of Death 4c. County of Death

5. Social Security Number 120 M 2 F 213 80 1364

10b. County

BALTIMORE If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Oct. 3, 1959

Usual Residence of Decedent 10a. Stete

10c. City, Town or Location

Yrs

7. Age (In yrs. last birthday)

Maryland

Maryland

Baltimore

10d. Insida City Limits 1 Yes 2 No

10e. Street and Number

10f. Zip Code 21230 10g. Citizen of What Country? U.S.

202 East Fort Avenue 11. Meritel Stetus

12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give

Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

14. Race - American Indian, Black, White, etc. Specify: White

1 Never Married 2 Married 3 Widowed 4 Divorcad

If Yes, Give Year or Dates: 15. Decedant's Education (Specify only highest grade completed) College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

22. Name and Address of Fecility

1 ☐ Yes 2 No Specify:

16b. Kind of Business/Industry

Elemantary/Secondary (0-12) 10th

Laborer

Various 18. Mother's Name (First, Middle, Maiden Surname)

17. Father's Name (First, Middle, Last)

Isaac Gollahon

mother

Ruth Weiford

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Streat and Numbar or Rural Route Number, City or Town, State, Zip Code)

Ruth Gollahon

202 East Fort Avenue 20b. Placa of Disposition (Name of cemetery, crematory or other place)

Baltimore, Maryland 21230 20c. Location - City or Town, State

20a. Mathod of Disposition 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Othar (Specify)

Sacred Heart of Jesus

2/18/99 Baltimore, Maryland

ranciocidas 23u. Part1. Enter the disease, or a shock, or heart failure. List

4001 Ritchie Highway cations that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest,

Gonce Funeral Home P.A. Baltimore, Md. 21225

Immediate Cause (Final disaase or condition resulting in death)

NARCOTIC INTOXICATION

Dua to (or as a consequence of):

Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of)

Due to (or as a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Found at home

23b. Did tobacco use contributa to the cause of death?

1 Yes 2 No 3 Probably 4 Hinknown

24a. Was an autopsy performed?

24b. Were autopsy findings eveileble prior to completion of cause of death?

Approximate ntervel Between Onset and Death

26. Place of Death (Check only one)

1 Yes 2 No

25. Was case referred to medical axaminer?

1 🖄 Yes 2 🗆 No 27. Mannar of Death

1 Natural

2 Accident

3 ☐ Suicide

4 Homicida

5 Pending invastigation 6 X Could not be

28a. Date of Injury (Month, Day Year) found 2/8/99

Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidanca 6 Other (Specify) 28b. Time of 28c. Injury at Work? P found 9:40 М

1 ☐ Yes 2 🗓 No

28d. Describe how Injury occurred

Unknown

28f. Location (Street and Number or Rural Route Number, City or Town, State) 202 E FORT AVE.

29a. Cartifian (Check only one)

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29c. License number

29b. Signature and title of

28a. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify)

O.C.M.E.

29d. Date signed (Month, Day, Year) FEB. 09, 1999

30. Name end addre s of person who completed cause of daath (Item 23a) (Type, Print)

estance 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year)

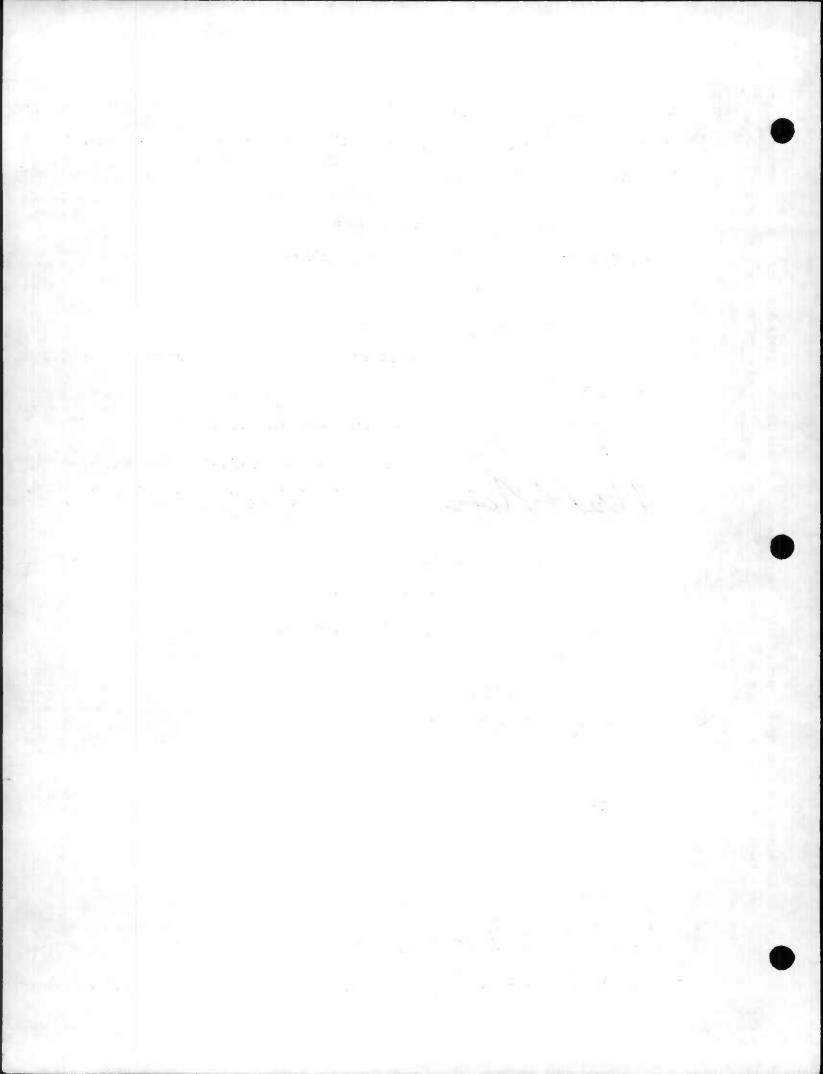
Registrar

FEB 23

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

A Polity Name (if not spatution, jive street and number) 10		at his and	4-1		Cei	rtificate of	Death			Reg. No.	U	1260
a Facility Name (If not institution, plus served and number) The North North State (If not institution, plus served and number) The North North State (If not institution, plus served and number) The North North State (If not institution, plus served and number) The North North State (If not institution, plus served and number) The North North State (If not institution, plus served and number) The North North State (If not institution, plus served and number) The North North State (If not institution, plus served and number) The North North State (If not institution, plus served and number) The North North State (If not institution, plus served and number) The North North State (If not institution, plus served and number) The North North State (If not institution, plus served and number) The North North State (If not institution, plus served and number) The North North State (If not institution, plus served and number) The North North State (If not institution, plus served and number) The North North State (If not institution, plus served and number) The North North State (If not institution, plus served and number) The North North State (If not institution, plus served and number) The North North State (If not institution, plus served and number) The North North State (If not institution, plus served and number of n	cian 1. Decede	nt's Neme (First, Mid			,				Month	Day		3. Time of Death
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MD N/A Baltimore 10t. Zp Code 10t. Zp Cod		10b. Count		10c. City							1	1 No 2 □ No
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exeminer? 1 Yes 2 No 27. Menner of Deeth 1 Maturel 2 September 2 September 3 DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 28b. Date of Injury 28b. Time of Injury	25 Was a	ase referred to media	al				26 Diago	of Death			1	162 5 1MO
27. Menner of Deeth 1	exemi	ner?	Hoenital:	□trinationt 2□	ER/Outpetion	nt 3 DOA O	hor:				ner (Snecil	v)
29e. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 28d. Location (Street end Number or Rurel Route Number of Rur		r of Deeth	28e. Da		28b. Time o							,
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29b. Signature and title of certifier 29d. Dete signed (Month, Dey, Year) P3585 Tebruay, 19, 199	3 □ S 4 □ H		mined 200. FI	ece of Injury - At ho illding, etc. (Specify	me, farm, str	reet, fectory, office		:	28f. Location (City or To	Street end Numb wn, Stete)	ber or Rure	el Route Number,
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30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JOSEPH Mark Savitt Goo North Walk St. Boltinare, MD 21287	_ <	1	· Journe D		1000	Inn 47	200					1,1979
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31. Date filed (Month, Dey, Year) 32. Registrar's Signetura	31 Pare #	LON IVO	1 201 1	Pagistaria Since	OND	rth Wa	ILC 5	24.	170141	were 1	ND	C/C8+1+



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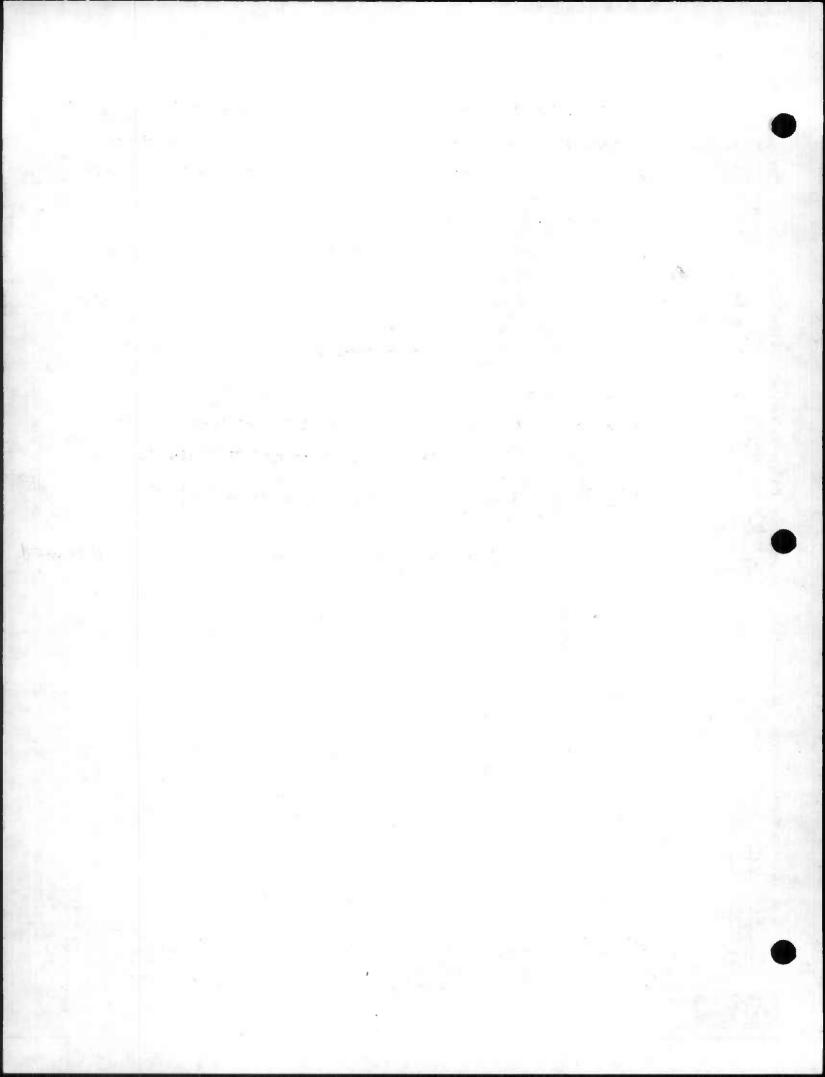
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Year **Physician** 21, 1999 3:35AM February Frankie Elizabeth Harman /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Baltimore Glen Arm Glen Meadows Health Center If Under 1 Year | If Under 24 Hrs. Birthplace (Stata or Foreign Country) 5. Social Sacurity Number 6. Sax 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 M 2 A F Yrs. Dec. 13 1906 Maryland Director 214-22-1744 92 Usual Rasidanca of Decedant the Marylend 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 PNo Director MD Baltimore Glen Arm 10f Zip Code 10g. Citizen of What Country? 10e Street and Number filed within 72 hours effer deeth with Hyglene. other than "natural", or items 23s or USA 21057 11630 Glen Arm Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Evar in U,S. Armed Forcas? 14. Race - American Indian, Black, Whita, etc. 1 ☐ Yas 2 ☑ No If Yas, Giva 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: p White 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Etamantary/Secondery (0-12) Collega (1-4or 5+) +2 permit. Pages 1 and 2 should be filled wit.
Department of Health and Mental Hyglens Important: if item 27 is marked other that any lojury or other traumatic event, that page. Education School Teacher 18. Mother's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middle, Last) Be Harry C. Wheatley Bertha Coulbourne 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1911 Haverhill Rd. Baltimore, MD. 21234 Mrs. Frances Bateson/Daughter 20a. Mathod of Disposition 20b. Plece of Disposition (Name of cematary, crematory or other place) Data 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata Dulaney Valley Cemetery 2-23-99 Timonium, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final One much diseasa or condition rasulting in daath) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or injury that initiated evants rasulting in death) Lest Dua to (or as a consequence of): Box 68760 physicien Physician/Medical Dua to (or as a consequence of) signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part t. Records, P.O. 1 | Yes 2 No 3 | Probably 4 | Unknown Artery disease by 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? peed 1 Yas 2 TNo 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attending Physician: Be 25. Wes casa rafarred to medical axaminar? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) ٩ 1 Yas 2 No 1 | Inpatiant 2 | ER/Outpatient 3 | DOA 28a. Data of Injury (Month, Day Year) uneral 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 24 hours after death. Funeral Director: After 1 Naturat
2 Accident 5 Panding invastigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 6 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. edical 29a. Certifian (Check only one) within 2 the 29b. Signature and title of cegifie 29c. License number 29d. Data signed (Month, Day, Year) 125205 un nd cause of deeth (from 23a) (Type, Print) N. Charles St. Bolto. MJ 21208 643mC 32 Floortrar's Signatura State

DHMH 16 Rev 6/95

Registrar

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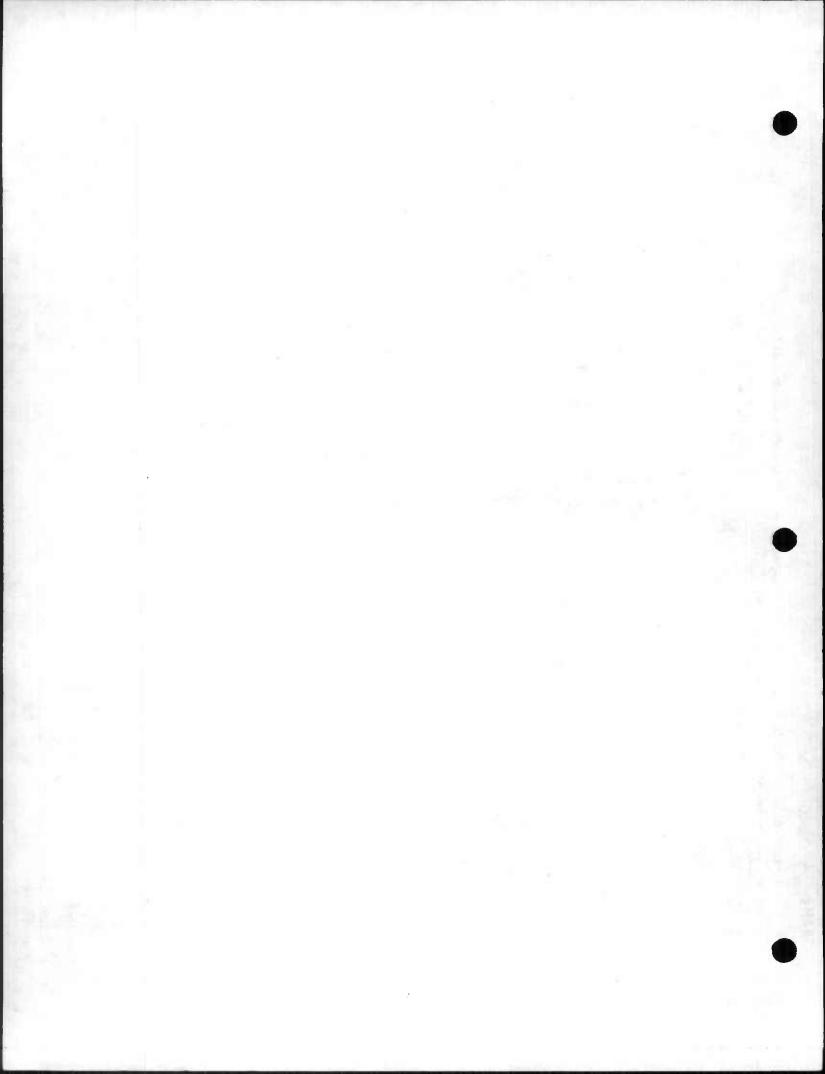
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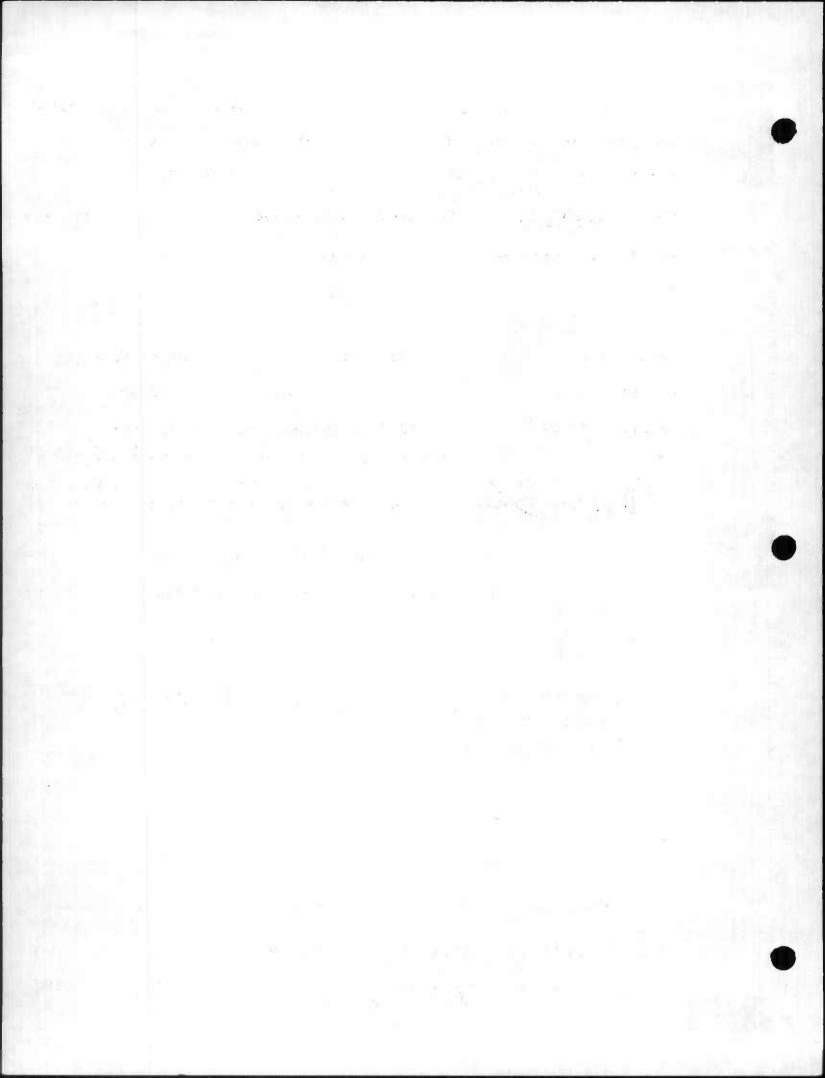
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ician	WM.C.March FH 1101 E. North Avenue 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximate										
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DHMH 16 Rev 6/95



Division of Vital Records, P.O. Box 68760,

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Physician

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f ahow the Medical Examiner must be notified at

filed within 72 hours after. Hygiene. Ither than "natural", or Ital

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permit. Page Department of Important: If any injury or

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Hospital or Attending Physician: after death. in by To the Hospital o within 24 hours af To the Funeral D completely filled i

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Was case referred to medical 1 Yes 2 No 27. Menner of Deeth 1 X Neturet 2 Accident 3 Suicide 6 ☐ Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner steted. 29e. Certifier (Check only one)

29b. Signature and title of certifier

K.S.RAO.M.D

D43462

29c. License number

29d. Date signed (Month, Dey, Year) FEBRUARY 17,99

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)) < . S - R A O · M · D NORTHWEST HOSPITAL CENTER RANDALLSTOWN MO

31. Dete filed (Month, Dey, Year) FEB 2 3 1999 32 Registrer's Signeture

State

Surror III, is true.

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middla, Last) 2. Data of Deeth **Physician** CTHE HETZNER FEBRUAR 14:20 /Medical 4b City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner CENTER MERCY MEDZIAL N/A 5. Sociel Sacurity Number If Under 1 Yaar Months Devs If Under 24 Hrs. Hours Min. 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** 1□M 2 F Deys 79 Yrs. Director 220-05-4958 July 16, 1919 Maryland Usuel Rasidance of Dacedent with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Manylen Department of Heelth and Mental Hydiens. Important: If them 27 is ansked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examine must be notified at 1X Yes 2 □ No Director Md. N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 600 Light St. #505 21230 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, atc.) 14. Rece - Amarican Indian, Bleck, White, atc. 11. Maritel Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No p Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Bualnass/Industry Elementery/Secondary (0-12) 12th Grade College (1-4or 5+) Secretary State of Maryland 17. Fethar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumame) John Vahle 2 Ruth Engelhart 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 600 Light St. #505 Balto., MD. Husband Paul Hetzner 21230 20e. Method of Disposition

1 Burial 2 Cremetion 3 Removal from State 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stete 2/22/99 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore Cemetery Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name end Address of Facility McCully-Polyniak Funeral Home, P.A. Baltimore, MD 21230 23a. Part1. Enter the disaasa, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** LISSS THAN /Medical Immediate Ceuse (Final HYPOXIA disease or condition resulting in deeth) 2 Hours Examiner Due to (or es e consequence of): Examiner physician end s the burial-transit death certificete be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated eventa resulting in death) Lest Due to (or es e consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): use Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. deteched Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown FERRUSIEDN þ 24b. Were autopsy findings aveilabla prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? Completed peen hes 2 No 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: Affer this certifica completely filled in by the funeral director, Be 25. Was cese referred to medical axaminer? 26. Place of Death (Check only one) Hospitel: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To 28e. Data of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 27. Menpar of Deeth 28d. Describe how injury occurred 28b. Time of 1 Naturel 5 Pending 1 Yes 2 No 2□ Accident Investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1🗹 Certifying Phyalcian: To the best of my knowledge, death occurred et the time, dete end plece, end dua to tha causa(s) and menner as stated. Medical (Check only one) 2 Medical Examiner: On the besis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature 300 file of Continue 29d. Data signed (Month, Dey, Year) 29c. License number D 0023261-MAD FEBRUARY 18, 1999

301 SAZET PAUL PURE

21202

BAYEMENS NARYLAND

Registrar

State

30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

32. Registrer's Signature

MOCHAEL SAWBAT, MO

31. Dete filed (Month, Dey, Year) FEB 2 3 1999

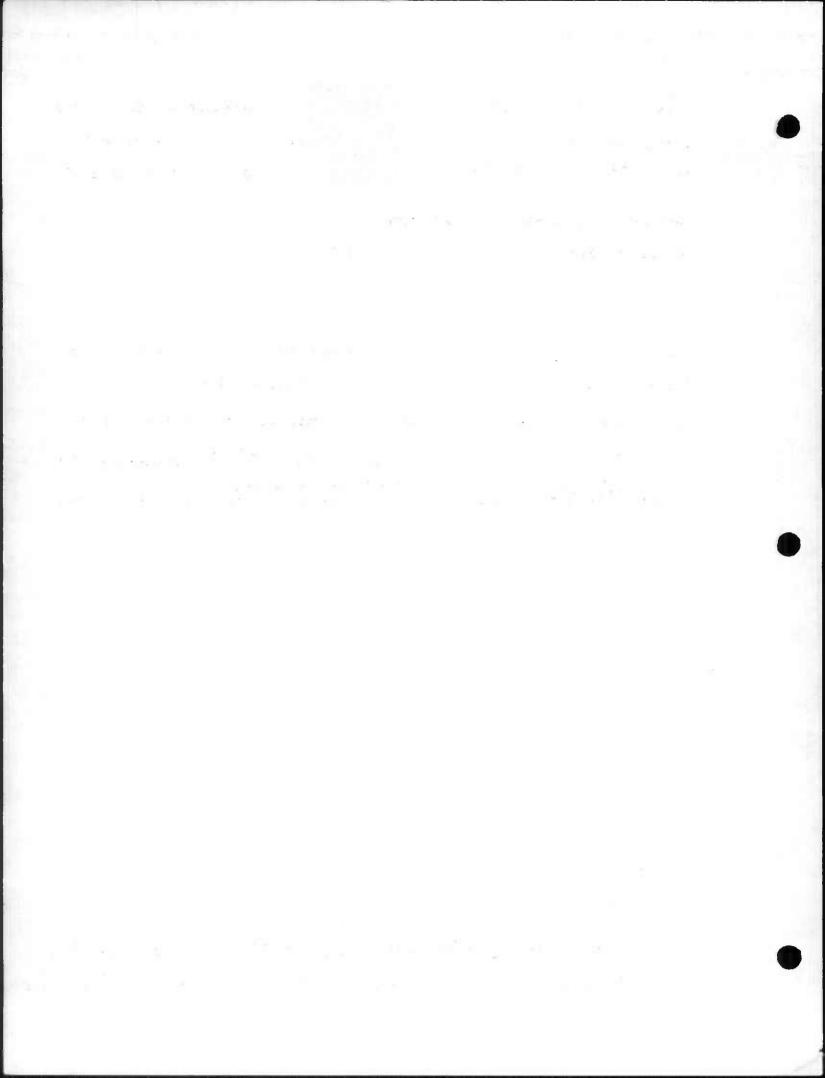
DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

						Certificate of	Death		Reg. No. 9	05266
в	Physic	an	1. Decedent's Neme (First, Middle, La					2. Dete of Det Month		3. Time of Deeth
	/Medi		Jessie Leona	a Holmes				Februar		999 5:55 AM
	Exami	er	4e. Facility Neme (If not Institution, give	and the second second			4b. City, Town, or L	ocation of Deeth	. Internation	
	۶		Chesapeake Future		**	hdev) If Under 1 Yeer	Arnold If Under 24 Hrs.	T		Arundel
۱	Funeral Director		218-16-0789	Sex 7. Age 1□ M 2☑ F 75	(In yrs. lest birt	rs. Months Deys		8. Dete of Birt (Month, Da July 1	y Year) 5, 1923	Birthplece (State or Foreign Country) Maryland
	and **		Usuel Residence of Decedent 10e. Stete 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Manyta f sho	ō	Maryland Anne Ar	undel		nsville				1 ☐ Yes 2 X No
	r 28a-f show	rect	10e. Street end Number	0.1002		10f. Zip Code			10g. Citizen of W	/het Country?
	ath with	eral Di	802 Dogwood Trail			2103			USA	
21215-0020	hours after death with the Maryland uret; or items 23s or 28s-f show at Examiner must be notified at	by Funeral Director	11. Meritei Stetus 1 ☐ Never Married 2 ☐ Merrled 3 ☐ Widowed 4 ☒️Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes:		13. Wes Decedent of If Yes, specify Cut 1 ☐ Yes 2 No		pecify Yes or No Rican, etc.)	Specify:	a-American Indian, k, White, atc. White
5-0	72 Part 1	Completed	15. Decedent's E (Specify only highest gro	ducetion ede completed)	16e.	Decedent's Usuel Occu (Give kind of work done life. DO NOT use retire	petion during most of work	ding	16b. Kind of Bu	siness/Industry
121	within ana. then	du	Elementary/Secondery (0-12) Grade 9	College (1-4or 5-		ille. DO NOT use retire ssembly lin			Electro	-therm co.
		ပိ	17. Fether's Neme (First, Middle, Last	9	Α	SSEMBLY III	18. Mother's Nam	e (First Middle		
an	Mentel Mentel arked o	To Be	Dorsey O. Keys	,				Baubitt		•/
Maryland	s 1 and 2 should be filed if Health and Mentel Hyg Nem 27 is marked other other treumatic event,	Ĕ	19e. Informent's Neme/Reletionship	(Type, Print)	19b.	Mailing Address (Stree	t and Number or Ru	ral Route Numbe	er. City or Town.	Stete. Zip Code)
	1 and 2 Health and 27 Is		Ricky Holmes /	son	1	02 Dogwood				
Baltimore,			20e. Method of Disposition		20b. Plece of	Disposition (Neme of v, crematory or other ple	acel T	eb 24.	20c. Location -	City or Town, Stete
m			1 ☐ Buriai 2XX remetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Special]Removel from Stete (fy)		Crematoory	1	eb 24. 1999	Catons	sville, Md.
alti	교통론증		21. Signature of Funeral Service Lice			22. Neme end Addr Donaldson		Home D		
m	Depeni Impo any ir		6 Com	7			tt Avenue			land 20707
	-		23a. Part1. Enter the disease, or com shock, or heert feilure. List only	plications thet caused	the deeth. Do n					Approximete Intervel Between
	Physician		Shock, of fleet fellule. List only	One cease on each min	o.		^ .			Onset end Deeth
4	/Medical		Immediate Ceuse (Final disease or condition	resi	piral	ory to	ailur	2		14 days
п	Examiner		resulting in deeth)	1	Due to (or es e o	onsequence of):				
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al F	Tha cata pag		surgi	con Tla	pan	dskin	gratt	101	res 2 No	1 □ Yes 2 □ 10
Vital	sician: Tha law cartificata hes b lirector, paga 2 s	Be	25. Wes cese referred to medicel examiner?	Hospital:		100	26. Plece of Dea			
of	Physician: this cartific ral director,	- To	1 ☐ Yes 2 No 27. Menner of Death	1 ☐ Inpatien		petient 3L DOA			dence 6 Othe	
on	ding F h. After funer	tion	1 Natural 5 ☐ Pending	(Month, Dey		jury Wo	ork?]Yes 2□No	200. Describe i	low injury occurr	PG
Division	Attending or death. ector: After by the fune	fica	3 ☐ Suicide 6 ☐ Could not b	e no piece diei.	rv - At home, fer	m, street, fectory, office	,,,,,	28f. Location (S	Street end Numbe	er or Rurel Route Number,
5	after after d in t	Certification:	4 Homicide	building, etc.	(Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Tou	vn, State)	
	To the Hospital or Attending Physician: Tha is within 24 hours after death. To the Funeral Director: After this cartificate he completely filled in by the funeral director, page	edical C	29e. Certifier (Check only one) Cartifying Ph	nysician: To the best of ninar: On the basis of e end menner stet	examinetion end	death occurred et the t Vor Investigetion, in my	me, date end plece, opinion, deeth occur	end due to the red at the time,	ceuse(s) end mai date and place, e	nner es steted. and due to the ceuse(s)
	o the o the omple	Med	29b. Signeture end title of certifier	One mention state		29c. Licen	se number	T	29d. Dete signed	(Month, Day, Year)
	F 3 F 8		in	refe	22	e D	41955	_		
		-	30. Name engladdress of person who	completed cause of de-	eth /Item 22a) /	Type Print	1.100		1	22-99
11			Elsecco	1 Hon	M (Main 238) (1454 B	BAB	evd.	Arno	1d MD 21012
d	Sta Registr	-	31. Dete filed (Month, Day, Year)	32. Registrer	r's Signeture	6 6				

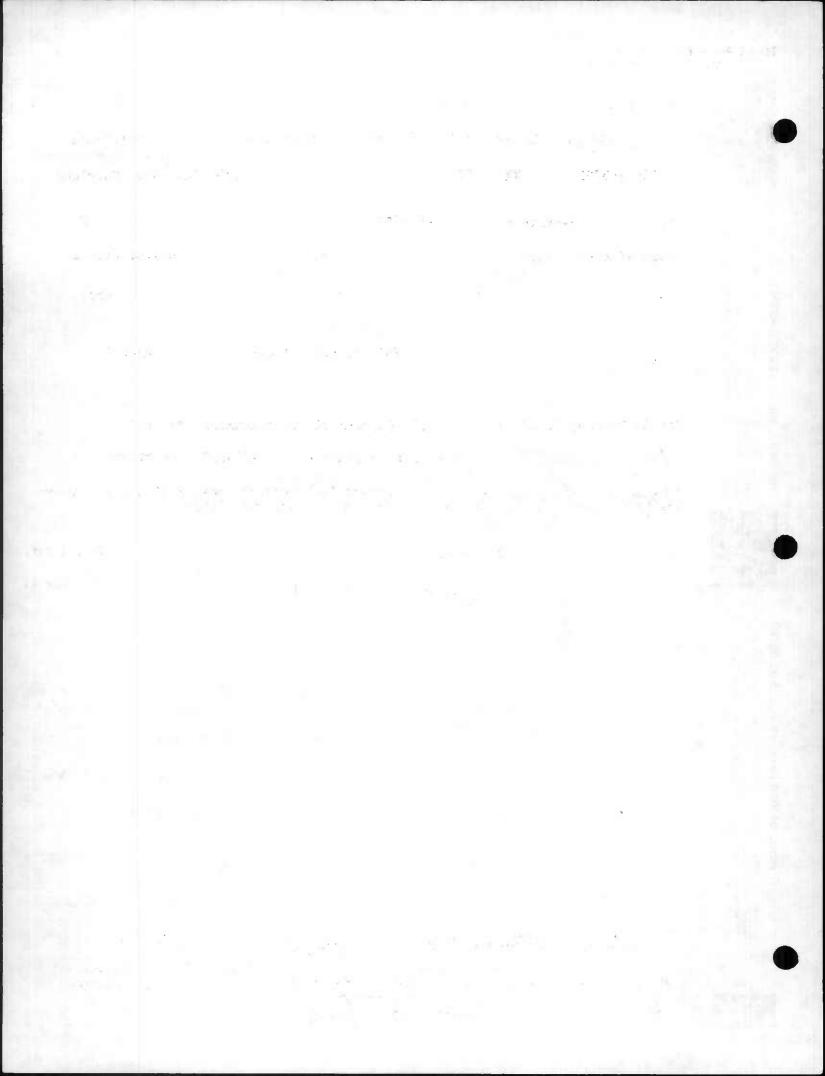
DHMH 16 Rav 6/95



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I tem#	#8 perFHG768 2/23/99	EW		Cen	tificate	e of	Death			Reg. No.	U	0601	
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/Medical	4a Facility Nama (If not institution,			···a· ga·				wn. or Lo	cation of Death		///	,,,,,	
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eral	7-	6. Sax 7. /	Aga (In yrs. lasi		If Undar Months		If Undar 2	24 Hrs.	8. Data of Birt (Month, Da			laca (Stata or Foraign	1
or	212-22-8255	1□M 2□F XX	91	Yrs.	Months	Days	riours	IVIET.	Feb. 1	2, 1999		ryland	
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	Debbie Engram,									MD 212			
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	Burial 2 Cramation Donation 5 Othar (Sp		a l	on Pa				2	/15/99	Balti	more,	MD	
	21. Signatury of Funeral Service L			7 22.	Nama an	d Addra	ss of Facilit	у					
	May 8 1	KINO UM	1100								ilker	ns Avenue	
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ical E	Sequantially list conditions, if any, laading to Immadiata causa. Entar Undarlying Causa. (Disaasa or injury that initiated avants	C									i		_
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		28a. Data of Ir (Month, I	Day Year) 28	8b. Tima of injury		8c. Injui			28d. Dascribe	how injury occur	red		
Certification:	2 Accidant invastig	ation			М		Yas 2		004 1	Ctrant and the		al Cauta Mumb	
FILE	4 Homicida datami	and 28a. Place of	Injury - At home atc. (Specify)	a, farm, stra	at, factory	, office			28f. Location (City or To	oreer and Numb wn, Stata)	er or Hura	al Routa Number,	
Medical Certification: 1	20a Carifier 4 Carifida	Dhuelelen, To the ho	at of my knowle	doe doeth	annurrad :	at the ti-	ma data an	d place	and due to the	course(s) and m	DDGC 8.C.C.	totod	
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Z E	29b. Signatura and titla of certifiar				290	. Licans	a number			29d. Data signe	d (Month,	Day, Year)	
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	30. Nama and addrass of person v		,		Print)	0	0 12	1	Thurs	2/12/ Horkins Medical	Ran	rie (.)	-
	Michael West		1.D.	Med:	Cal	Resi	lesof	J	Ouns	Medical	Ce	inter	
State	31. Data filad (Month, Day, Yaar)	32. Rag	strar's Signatur	- married States		-	C. or			1			
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DHMH 16 Rsv 6/95



Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Year **Physician** FRANCIS PATRICK HEALEY chruary 201999 /Medical 4a Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Center | | HUnder 1 Year Hospital C. 7. Age (In yrs. last birthday) Rosedale K If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) tranklin Square 6. Sex. 1 ☑ M 2 ☐ F 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Deys Months Yrs 213-07-2555 81 DEC. Director 13, MARYLAND Usual Residence of Decedent death with the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours efter death with the Manylan Depertment of Health and Mental Hygiene. Throptant: If term 27 is marked other than "natural", or frems 23a or 28a-f show any injury or other treumstic event, it is Meanics. Examine must be notified as 1 Yes 2 No Director MARYLAND HARFORD BEL AIR 10e. Street end Number 10f, Zip Code 10g. Citizen of What Country? 356 POINT TO POINT ROAD 21015 S. A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: WW I I 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: þ 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) YEARS Elementery/Secondary (0-12) MANAGER/SUPERVISOR STEEL COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Peges 1 end 2 should be nent of Health end Mental WILLIAM HEALEY 2 MARGARET ENGELBACH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) KEVIN M. HEALEY (SON) 356 POINT TO POINT ROAD, BEL AIR, MARYALNO 21015 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removel from State 4 Donetion 5 Other (Specify) 2/23/99 BALTIMORE, MARYLAND SACRED HEART OF JESUS 21. Signature of Funeral Service Licensee SCHIMUNEK FUNERAL HOME INC. BREHMS LANE, BALTIMORE, MARYLAND 21213 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical fmmediate Ceuse (Finel a. Cholangio carcinoma Gue to (or es e consequenca ot): 3 months diseese or condition resulting in death) **Examiner** Examiner ding physician and se es the buriel-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Hicate Due to (or es e consequence of) been signed by the should be detached Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en eutopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No After this certificate Be 25. Was case referred to medical 26. Piece of Deeth (Check only one) Hospital: 1 Nation 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: Affer th completely filled in by the funeral 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end placa, end due to the ceuse(s) end menner as stated. 2 Madical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Dey, Year) 29b. Signeture and little of certifier 29c. License number

February

21237

maryland

Square Drive

State Registrar 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Merino

Rolando

31. Dete filed (Month, Dey, Yeer)

FEB 2 3 1999

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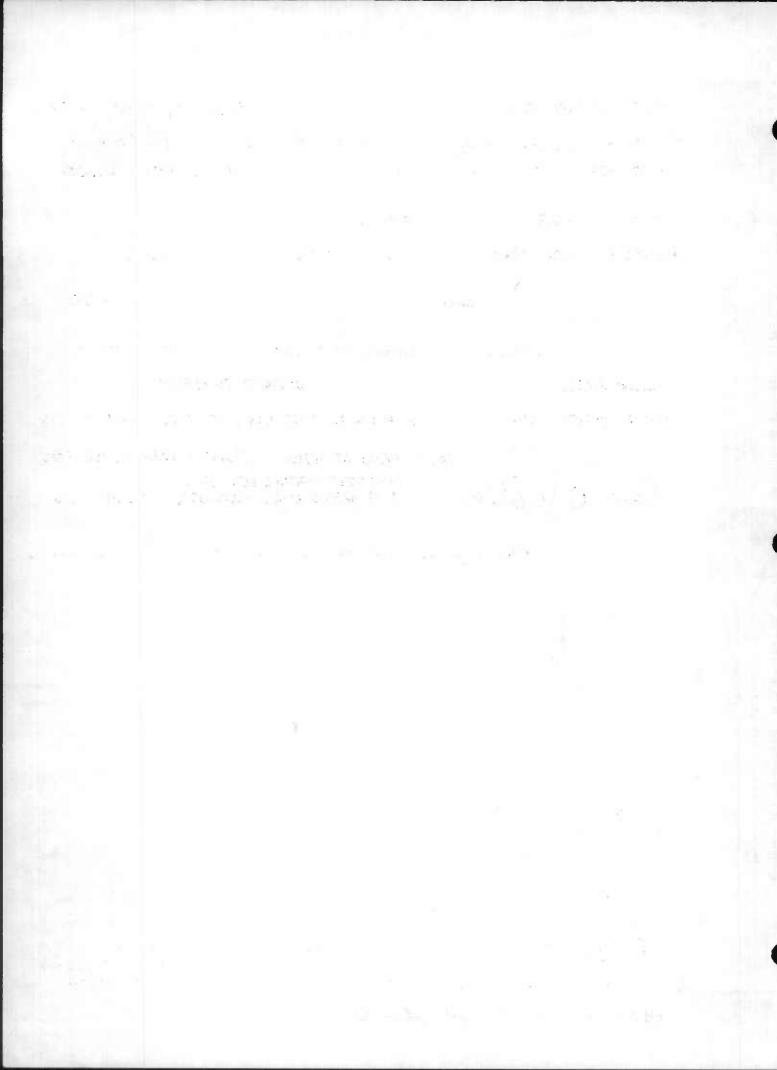
32. Registrer's Signeture

Franklin

DHMH 16 Rev 6/95

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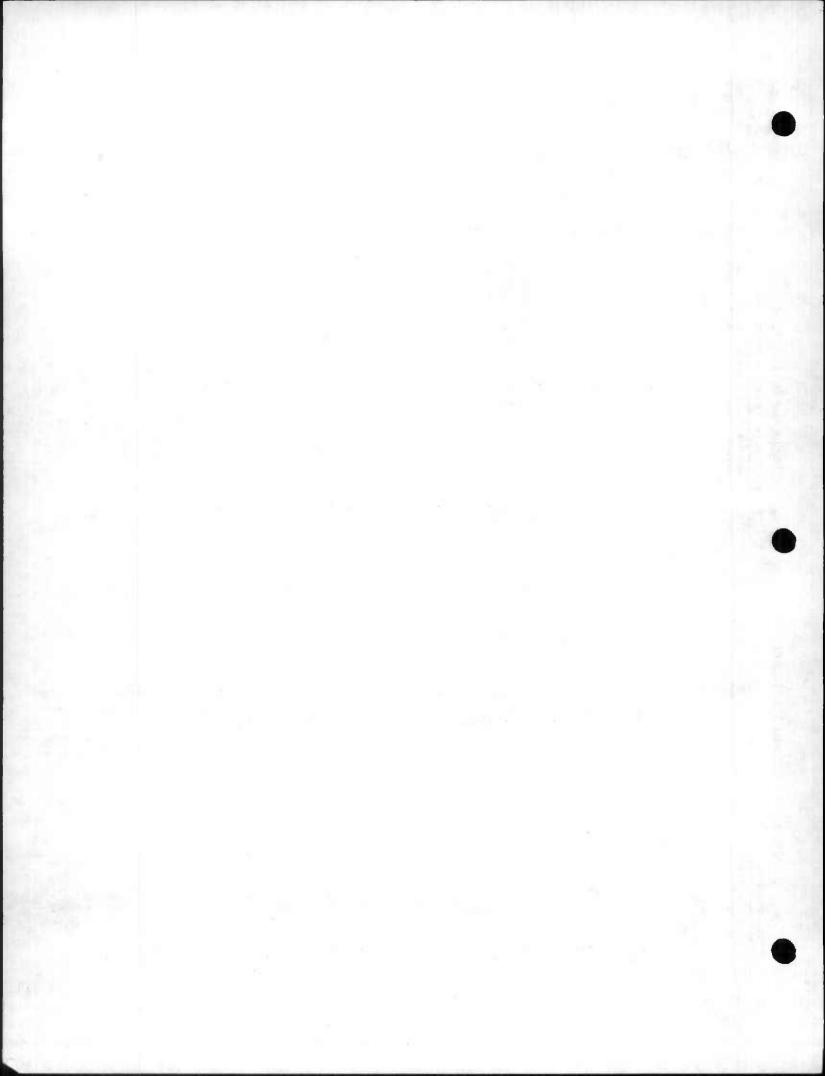


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No -1. Decedent's Name (First, Middle, Last) 2. Dele of Death 3. Time of Deeth Month **Physician** Frederick Hamer Sr. 1999 6:50 PM February 21 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3402 McShane Way Dundalk Baltimore If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1₩ 2□F Months Days 212-07-8366 Yrs. 86 June 4, 1912 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinal mast be notified at 1 ☐ Yes 2 XNo Director Baltimore Dundalk 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? 21222 USA 3402 McShane Way 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Bleck, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Detes: 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White λq 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within 72. Department of Health and Mental Hyglene. Important: if item 27 is marked other than "nett eny lijury or other traumatic event, the Medical page. Elementary/Secondary (0-12) College (1-4or 5+) Chemical Products Machine Operator 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Anna I. Knight George M. Hamer 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Towson, MD 21286 8142 Pleasant Plains Rd Thomas H. Hamer /son 20b. Place of Disposition (Name of cemetery, cremetory or other place) Feb 25 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 1999 Gardens of Faith Baltimore, MD 22. Neme end Address of Fecility 21. Signeture of Funeral Service Licenses Connelly Funeral Home of Dundalk Inthony 7110 Sollers Point Rd 23a. Pertf. Enter the discusse or complications that caused the dem. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart leilure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical ongestive Examiner Due to (or es e consequence of): by Physician/Medical Examiner remit Cardio cu yopo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated assets) Due to (or as a consequence of): physician Box 68760 that initiated events resulting in death) Last Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 10 100 2 No 3 Probably 4 Unknown Stroke Atrial Fib-ilkation 工工 Dun 24b. Were eutopsy lindings eveilable prior to completion of cause of death? 24a. Wes en autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 8 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 212 No 10 this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Certification: Aftert or Attending 5 Pending investigation after deeth.

Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide the Hospital or Atte hin 24 hours after de the Funerel Diracto upletely filled in by th 28e. Place of Injury - At home, Ierm, street, lectory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and menner es stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. To the To the To the Complet 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of codified D0050648 address of person who completed cause of death (Item 23a) (Type, Print) Beacham Cliwic Scott SSOS HOPKINS Baltimore mo 21204 Donald Bayview Cv. 31. Date liled (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Month Elizabeth M. Harshaw February Ĩ8 1999 1:20 pm 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Genesis Eldercare - Severna Park Severna Park Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Months Deys Hours 1 M ACKE 86 195-40-3203 Yrs April 18,1912 Pennsylvania Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Severna Park 1 ☐ Yes XIX No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 24 Truckhouse Road 21146 USA 11 Marital Status 12. Wes Decadent Ever in U,S. Armed Forces? Was Decadent of Hispento Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Reca - American Indian, Bleck, White, etc. Yes 2 No 1 Never Married 2 Married 1 Yes 2 XNo Specify: White Specify: 3 X Widowed 4 ☐ Divorced Year or Detes: 15. Decadent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) John McFarland Mary L. Bille 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Archie Harshaw, Jr. - Son 802 Lucky Road, Severn, MD 21144 20b. Pleca of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremetion 3 ☐ Removel from State Holy Sepulchre 4 ☐ Donetion 5 ☐ Other (Specify) 02/23 Philadelphia, PA 21. Signature of Euneral Service Li Name and Address of Fecility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death Immediete Cause (Finel disease or condition resulting in death) en Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest s e consequença of) e to (or es e consequença of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 Tyes 2 No 1 ☐ Yes 2 ☐ NO 25. Was case referred to medical 26. Plece of Death (Check only one) exeminer 1 Yes Other: 4 Norsing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA

Physiclan /Medical Examiner

The law requires that the death certificata be executed

Attending Physicien:

death.

or A after

Hospital 6

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

.Funeral

Director

28a-f show

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Department of Haalth e Important: If Item 27 le eny injury or other tree

Examiner must be notified at

Director

Funeral

Be Completed by

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MD

Manyland

the

daeth

Pages 1 and 2 should be filed within 72 hours efter nent of Haalth end Mantel Hygiene.

Baltimore, Maryland 21215-0020

Physician/Medical Examiner ģ Completed Be Certification: To

for use as the burial-tran

27. Manner of Death

2 Accident 3 Suicide

4 Homicide

5 Pending investigation

6 Could not be

1 SNatural

signed by 8 peen paga 2 certificate has director, this o erel Director: After thi filled in by the funeral within 24 hours a
To the Funeral C Medical

29a. Certifler (Check only one) Check only one) Contifue Physician: To the best of my knowledge, deeth properties of exeminetion end/or invariant manner stated.	occurred et the time, date and placa, end di estigation, in my opinion, deeth occurred at	ue to the cause(s) end manner as stated the time, dete and place, and due to the
29b. Signature and title of pertiller	29c. License number D20094	29d. Date signed (Mopth, Dev.
30. Name and address of person who completed cause of death (Item 23e) (Type, F	Print) BUTNIP MA	le, 2106
FEB 2 3 1999 Separation 1999	and)	

28b. Time of

Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

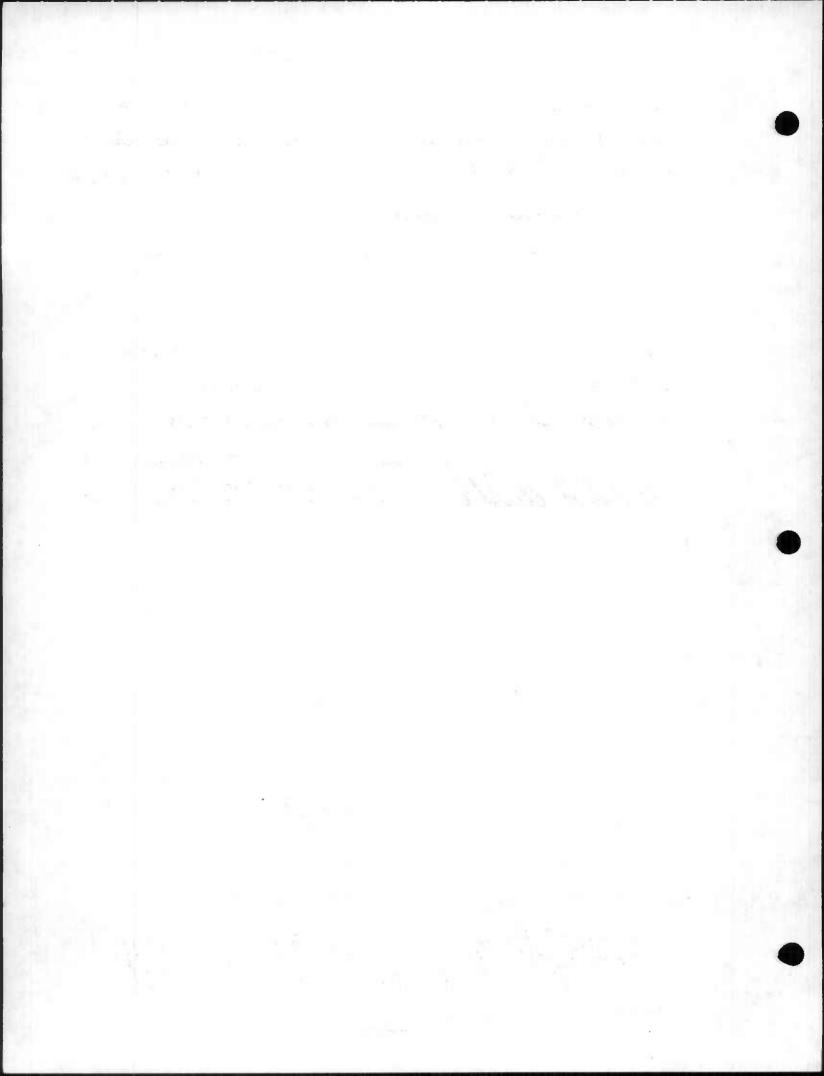
e time, dete and place, and due to the cause(s) 29d. Date signed (Mopth, Dey, Yeer)

28a. Date of fnjury (Month, Dey Year)

DHMH 16 Rev 6/95

State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 22, 1999 Feb. Calvin 1:15 A.M Hunter 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hart Herritage Nursing Center Street If Under 1 Year If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 15M 20 F Hours Days 213-07-6212 Oct. 14,1910 Usual Residenca of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Harford Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 14. Rece - American Indien, 1. Marital Status

1. Merital Status

1. Never Merried 2 Married Forces?

1. Never Merried 2 Married Forces?

1. Yes, Give Year or Dates: 2 1 1 5 4

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Pharmist Pharmacy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Anna Heineman John Hunter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type Print) McCarthy/ Daughter 1001 Tamworth Rd., BeLair, Md. 2 1015 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 2-25-99 Balto., Md. 21. Signature of Funeral Service Licansee Bradley-Ashton-Matthews Funeral Home, Inc. 23a. Pert1. Inter the dis ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, interval Between Onset and Death Consistive Hest Exiture Immediate Cause (Final disease or condition resulting in death) YEAMS Due to (or as a consequence of): 1 WK PREUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or es a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Aspiration Duc 24b. Were autopsy findings evallable prior to completion of cause of deeth? 24a. Was en autopsy performed? Swallowing Dizorder 1 Yes 2 No

Physician /Medical Examiner

permit. Peges 1 and 2 should be file Department of Health and Mentel Hy important: If flem 27 is marked othe any injury or other treumatic event, bace.

Physician

/Medical

Examiner

Director

Funeral

Md.

Funeral

Director

7 is marked other than "naturel", or frems 23s or 28s-f show freumatic event, the Modical Examiner, must be notified at

Baltimore, Maryland 21215-0020

Examiner 98

physician end s the burial-transit this death. or Attend after death Director:

Division of Vital Records,

þ Completed

Physician/Medical Certification: To

Hypertension.

25. Was case referred to medical examiner? 1 Yes 2 No

27. Menner of Death 1 Natural
2 Accident 5 Pending Investigation 6 Could not be 3 Sulcide

29a. Certifier (Check only one) 2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated.

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Dey Year)

NA

28b. Time of 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

28d. Describe how injury occurred NOW

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 1/2 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signeture end title of cartifier

MO

29c. License number D 39889

29d. Date signed (Month, Dey, Year) Feb 22 1889

Assisted

CARL

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

ALFRAD SPANN 615 W. MALPHA-1 RD Bel RIN MD 21014

31. Date filed (Month, Day, Year)

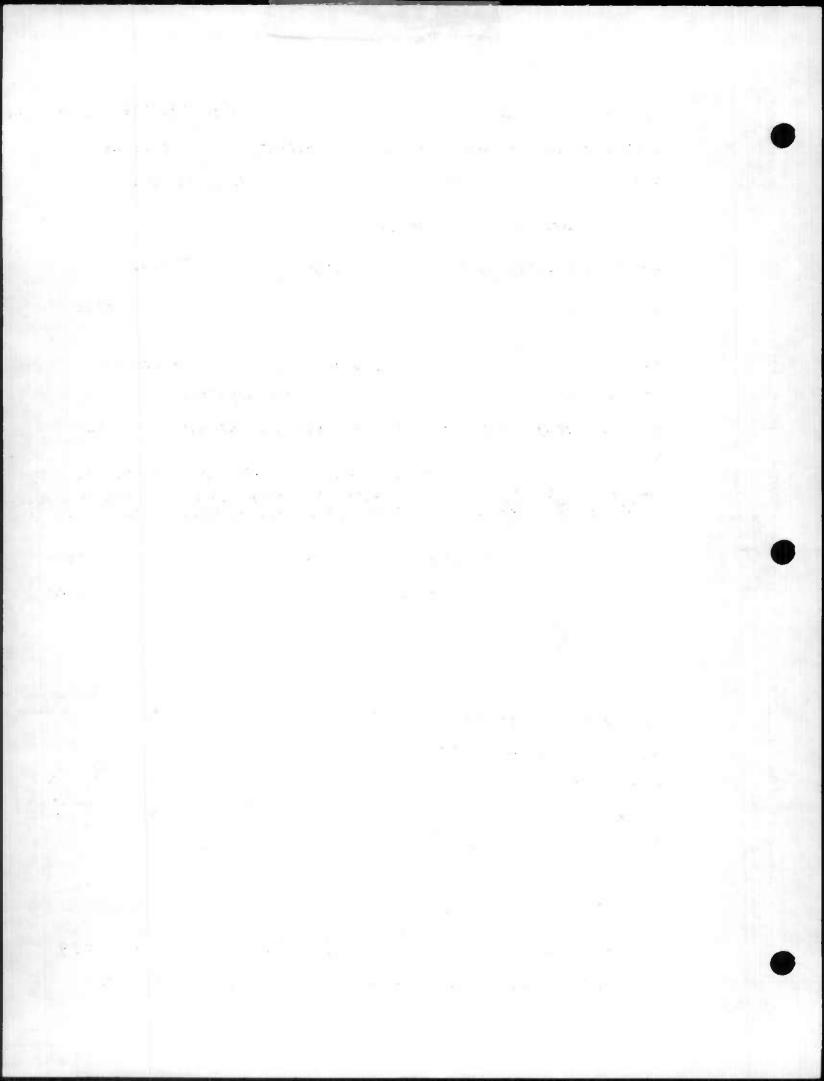
32. Registrer's Signeture FEB 2 3 1999 >

Registrar

Medical

24 hours a

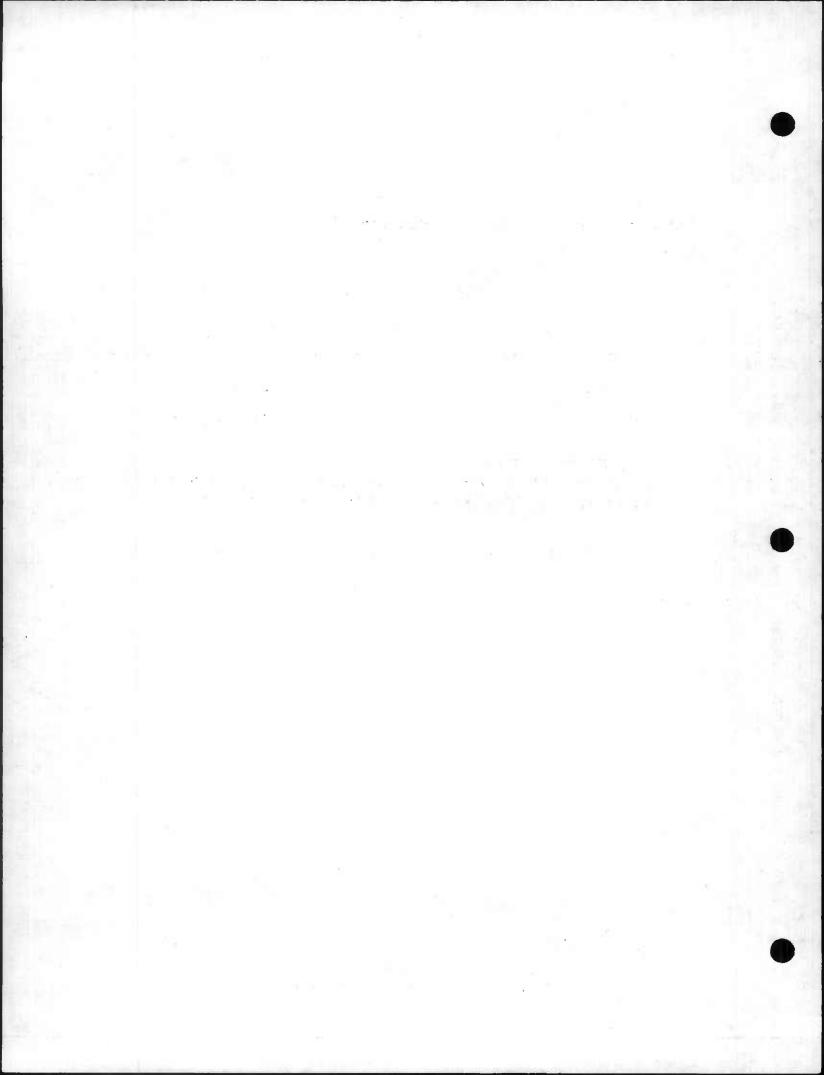
To the Hosp within 24 ho To the Fune completely fi



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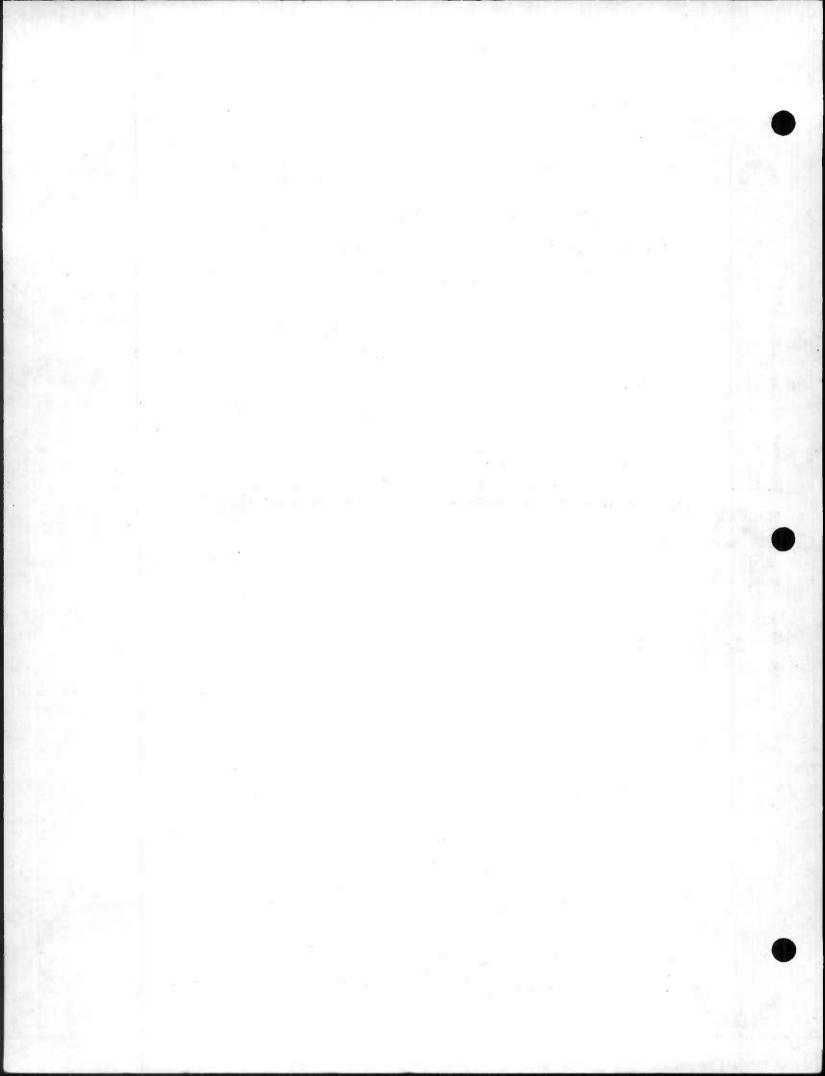
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ician									Month JAN	Day 21, 19	Year	1029 AM	
dical	Sheik D. Hase 4e Facility Name (If not institu		street and nu	mber)				4b. City, Town, or				1029 AM	
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al	5. Social Security Number	6. Sex			n yrs. last bii		Under 1 Year onths Days	If Under 24 Hrs Hours Min			9. Birthp	lace (Stata or Foreign	
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	Usuel Residence of Decedent 10a. Stete 10b. Cou	nhy		10	Oc. City, Tow	m or Locatio	00				1	Od. Inside City Limits	
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Director	Maryland N/A				Ba	altimo	Of. Zip Code			10g. Citizen of \	What Cour	trv?	
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2	1 Never Married 2 N	lerried	Armed For 1 Test Yes, Girl Year or D	2 Dyn	7 if Yes, specify Unknown 1□ Yes 28			Specify:	Specify	ec. ack			
ted	15. Deced (Specify only hig	lent's Edu			16a	. Decedent'	's Usual Occup	eation during most of wo	drina	16b. Kind of B	usiness/Inc	dustry	
or other treumatic event, the wages Exemple Trust or notine of the Completed by Funeral Director	Elamentery/Secondery (0-1)		College (1-4or 5+)		life. DO I	NOT use retired	d)					
	unknown	la last	unkn	own			unkno		ma (First Adia)		known		
De	17. Fether's Neme (First, Midd								me <i>(rirst, miaak</i> nknown	e, Maiden Suman	10)		
0	unknow		ne Print!		101	Meiling A	ddraes /Ctrant			her City or Town	Stata 7in	Code)	
price.	Off. McGee, 1B		Po, r (HH)			_			Rural Route Number, City or Town, Stata, Zip Code) Saltimore, MD 21202				
	20e. Method of Disposition 1 Buriai 2 Cremetic 4 Donetion 5 Other	n 3 🗆 R	emovel from	Stete	20b. Place o	of Dispositio		1	Date	20c. Location		wn, State	
	21. Signature of Funeral Service Ronal Co				ctor			ss of Fecility Comy Boar Marylar			lmore	Street	
dicai Examiner	Immediata Cause (Finel disease or condition rasulting in death) Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury the initiated events Due to (or es e consequence of): Due to (or es e consequence of):												
Physician/Medi	ther intered events resulting in death) Lest Due to (or es e consequence of):											a the cause of cleath?	
	Pert fl. Other significant cond	mons con	induling to di	Bath Dut n	ot resulting t	in the under	nying cause gr	veit in Parti.		Yes 2 No	tobacco use contribute to the cause of death? Yes 2□ No 3□ Probably 4☑ Unknown		
Completed by						Ы	82			is an autopsy formed?	av	ere eutopsy findings ailable prior to impletion of cause death?	
									10	Yas 2□No	10	Yes 2□ No	
Bec	25. Wes casa raterred to med axaminer?	ical						26. Place of De	ath (Check only	one)	1		
0	XIXI Yes 2□ No	H	lospital: 1 🗆	Inpatiant	2□ ER/O	utpatient :	3□ DOA Ott	4 LI Nursing	1 1 1 1	sidence 6 □Ott		(y)	
Cermications	E LI ACCIDAN	ding estigetion		th, Dey Y	ear)			ry et rk? ∣Yes 2 □ No		Street and Alum		al Double Aliente	
	4 Homicide	armined		of Injury ing, etc. (3		At homa, farm, street, factory, office 26f. Location (Street and Number or Ruseity) 26f. Location (Street and Number or Ruseity) City or Town, Stete)					or or mun	arrioute Number,	
enical	29a. Certifiar 1 Certification (Check only one)	ying Phys	er: On the b	best of masis of ax	amination ar	e, death occ nd/or investi	curred at the ti igation, in my o	ma, data and place opinion, death occ	e, and due to th urred et the time	e cause(s) and m e, data and place,	anner as s and due t	itated. the cause(s)	
IM	29b. Signeture end title of cert	ifier	m	N	(A.)		29c. Licens	se number "M.E		29d. Date signed JAN.			
	30. Name and eddress of pers	Pes	mplated caus	ne of deat				Baltimo	re, Mar	yland 21	201		
ate trar	FEB 2 2 19		32. F	legistrer's	Signeture	10	c. 11.1						



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.T	Λ	VI	L	C	

AMES IAVERY		State of Marylai		cate of			Reg. No.	05	273		
Physician /Medical	James Havery					2. Date of De Month JANUAR	Day Y 20, 199	Year 99	3. Time of Death $12:53A.M.$		
Examiner Funeral Director	4e Facility Neme (If not institution, given 5112 BELAIR ROAD 5. Sociel Security Number unknown 6. S			Under 1 Year riths Days	BALTIMOF If Under 24 Hrs. Hours Min.	RE Balti		imore City			
/lend	Usuel Residence of Decedent 10a. Stete 10b. County	10c. C	10c. City, Town or Location 10d. Ins								
e Men	Maryland Baltimo	ore City Ba	altimore		Kubi.				1 ☐ Yes 2 ☐ No X		
with the Me or 28s-fa	10e. Street and Number 5112 Belair Road		10	X. Zip Code 21206			U.S.A		7		
n 72 hours efter death with the Meryland "netural", or items 23s or 28s-f show accel Exerciper man be notified at	11. Mentel Status UNKNOWN 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ever in L Armed Forces@nkno 1 Yes 2 No If Yes, Give Yeer or Detes:	cedent Ever in U.S. orces@nknown 2 □ No ive 13. Wes Decedent of Hispanic Origin? (Sporces@nknown 13. Wes Decedent of Hispanic Origin? (Sporces@nknown) 14. Yes 2. In No Specify:				- 14. Rac	e - American ck, White, etc.			
c 1 4 4	15. Decedent's E. (Specify only highest grant processes of the secondary (0-12) Unknown	ducation	16a. Decedent's (Give kind life. DO N	of work done OT use retired	during most of wor	king	16b. Kind of Business/Industry unknown				
should be filed within and Mental Hygiene. marked other than smatic event, the Martin Be Comp	17. Father's Neme (First, Middle, Last				18. Mother's Nam unknow						
. 0 = 2	19e. Informent's Neme/Reletionship (unknown	Type, Print)		dress (Street	and Number or Ru	ıral Route Numb	er, City or Town,	State, Zip Co	xde)		
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than amphilyury or other treumatic event, the Bode. To Bia Comp	20e. Method of Disposition 1 Buriel 2 Cremetion 3 4 Donetion 5 30ther (Special	Removel from State	Place of Disposition cemetery, cremetor		ce)	Date	20c. Location -	City or Town	, Stete		
Departition Departments Imports any Injuine	21. Signature of Fundral Service License ROAAId S.	ade Director	timore	Street							
Sale be swedled by sician by sician by sician by sician and by sician and the bunal-transit the bunal-transit college of the sicial by s	Immediate Cause (Finel disease or condition resulting in deeth) Sequentially list conditions, if any leading to immediate	b	or as a consequence	ee of):	enlar	Diseas					
deeth certificate be executed e ettending physicien end ed for use as the burial-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last	c	or as a consequenc	s a consequence of):							
ach th		contributing to death but not re-	ven in Pert I.	23b. Did tobacco use contribute to the cause 1 Yes 2 No 3 Probably 4							
aw requires as been sign 2 should be						pari	en eutopsy ormed?	evaila	/		
yelclen: The I s certificate hi director, page					26. Place of Dea	ath (Check only		121	65 20110		
2 2 2	1 ☑ Yas 2 ☐ No	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	DOA Oth	4 LI Nursing F	tome 5 Resi 28d. Describe	dence 6 Oth				
tal or Attending P rs after deeth. at Director: After t led in by the funera Certification:	2 Accident investigeto 3 Suicide 6 Could not b 4 Homicide determined		28f. Location (City or To	Street and Numb wn, State)	ber or Rural R	loute Number,					
Hospi 24 hou Funer itely fill		ysician: To the best of my known that: On the basis of examine and menner steted.									
within 2 vithe comple		1.00		29c. Licens	se number		29d. Date signe	d (Month, Da	y, Year)		
	30. Name and address of person who	Cluste not	m 23a) (Type. Print		.M.E.	J	ANUARY	21,199	9		
State	Dennis J. 31. Dete filed (Month, Dey, Year)	hute Ma	1		n Street	, Baltin	ore, Ma	ryland	21201		
Registrar	EFR 9 9 1000	- Dras	19 km	2. 11.1							



Item 17 Per AB Film G768 2-22-99 rja Certificate of Death

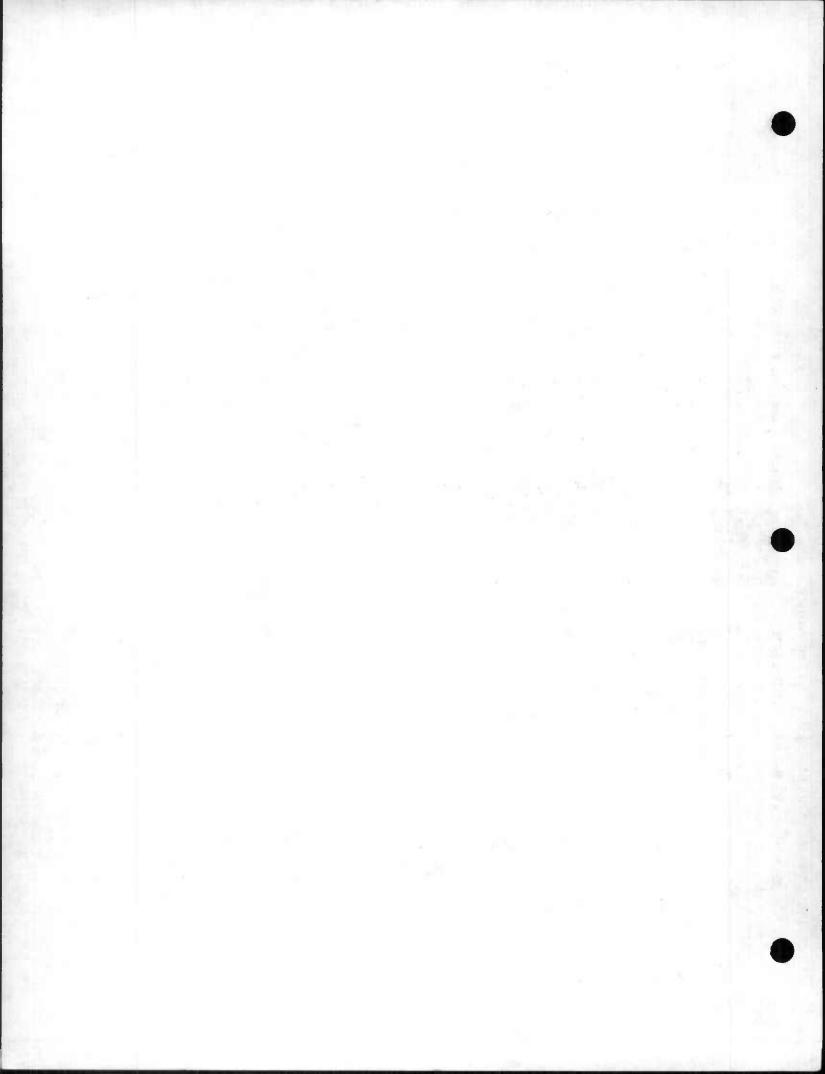
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Physician	1. Decedent's Name (First, Middle, LI MARGARGET S	OUSAN HIBB	Œ		CULT I	2. Date of De Month FERWAL	Dey	Year 994	3. Time of Death		
/Medical Examiner	4s Carliba Nama (Mantingthation of	ive street and number)			4b. City, Town, or L BETTESOA	1	h 4c. County	of Death	V		
Funeral Director		Sex 7. Age (In)	rs. last birthday Yrs.	Months Dey		8. Date of Bir (Month, Di Aug.	th ly, Year) 0, 1943	9. Birthpla Count Virg:	aca (State or Foreign y) inia		
D .	Usual Residence of Decedent 10a. State 10b. County	100	City Town or I	ocation				10	d. Inside City Limits		
oth with the Maryler 23s or 28e-f show the profitted at			nery Bethesda						1 ☐ Yes 2 ② No		
with the Mai		lighway		10f. Zip Code 2081			-		y?		
er des	11. Marital Status 1 □ Never Married 2 □ Merried	12. Wes Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give	n U,S. 13.	. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Spuban, Mexican, Puerto o Specify:	pecify Yes or No o Rican, etc.)	Blee	ck, White, e	tc.		
15-002 72 hours netural;			16a. Deci	edent's Usual Occ	upation e during most of worl	-	16b. Kind of B	usiness/Inde	ustry		
1 21215-0020 and within 72 hours aft yglene. wer than "natural", or ft, tra wed existent.	(Specify only highest gr Elementary/Secondary (0-12)	rade completed) College (1-4or 5+)	(Giv.	DO NOT use reti	red)	king	IImlen				
d 2		4		Edito	Editor Unknown 18. Mother's Nama (First, Middle, Maiden Sumama)				-		
yiand yield Mental Hyand	France and						Date of Birth (Month, Day, Year) Ug. 5, 1943 10d. Inside 10d. Ins				
Mar d 2 sh thend 17 le m treum	19a. Informant's Name/Relationship unknown	(Type, Print)		ling Address (Stre	et end Number or Ru	ral Route Numb	er, City or Town,	Stata, Zip	Code)		
0 00	20a. Method of Disposition 1 Burial 2 Cremation 3 [4 Donation 5 Other (Speci	Removel from Stete	b. Plece of Disp cemetary, cre	position (Nama of ematory or other p	lace)	Dete	20c. Location	City or Tov	m, Stete		
Baltimo permit: Pag Department Important: It eny injury o	21. Signature of Funeral Service Lice Ronald	S. Wade Dire	ector		less of Fecility natomy Boa			imore	Street		
Physician /Medical Examiner	23a. Phill. Enter the disease, of conduct, or heart failure. List only immediata Cause (Finat disease or condition resulting in death)	Phenmonia			ying, such es cardiac	or respiretory a	rrest,		Approximate Intarvel Between Onset end Deeth		
y # 5		SUBDURAL HEMATOM B									
60, be execute clen and burlet-trans	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury	Dua t	o (or es a conse	equence of):							
the deeth certificate be exacuted by the ettending physician and sohed for use as the buriel-frensit available.	that initiated events resulting in death) Last Due to (or es e consequence of):										
the deat y the ent y	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to 1 Yee 2 No 3 Protection 1 Yee 2 No 3 Protec										
Cords, v requires been sign ehould be								con	re autopsy findings ilable prior to apletion of cause eath?		
n: The lav						10	Yes 2000	10	Yes 2 No		
Vita	25. Was case refarred to medicat examiner?	Manadali y		10	26. Place of Dee	th (Check only	one)				
Of Vita Physicien: rithis certific oral director,	12 Yes 2□ No	Hospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatie	SUL SEL DON			how injury occur)		
Attending or death.	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year	Injury	W	ork? □ Yes 2⊠No		UT OF B				
Division of an area of a series death. In effector: Affect led in by the funer Certification:	3 Suicide 6 Could not be determined		281. Location (Street and Number or Rural Route Number, City or Town, State) 4C21 975-W35 Highway, 86777304 MO								
Division To the Hospital or Attending within 24 hours effer death. To the Funeral Director: Affei completely filled in by the fune Medical Certification	29a. Cartifier 1□ Certifying Pl	hysician: To the best of my miner: On the basis of exam and menner steted.									
To the comple	29b. Signature and title of certifier	mo (Ome	5)		nse number		29d. Date signe				
	30. Name and address of person who	completed cause of deeth (Item 23a) (Type	ROCKUV	UR PINE,	Dockvi	UE M	0 20) RSZ		

DHMH 16 Rev 6/95

State Registrar

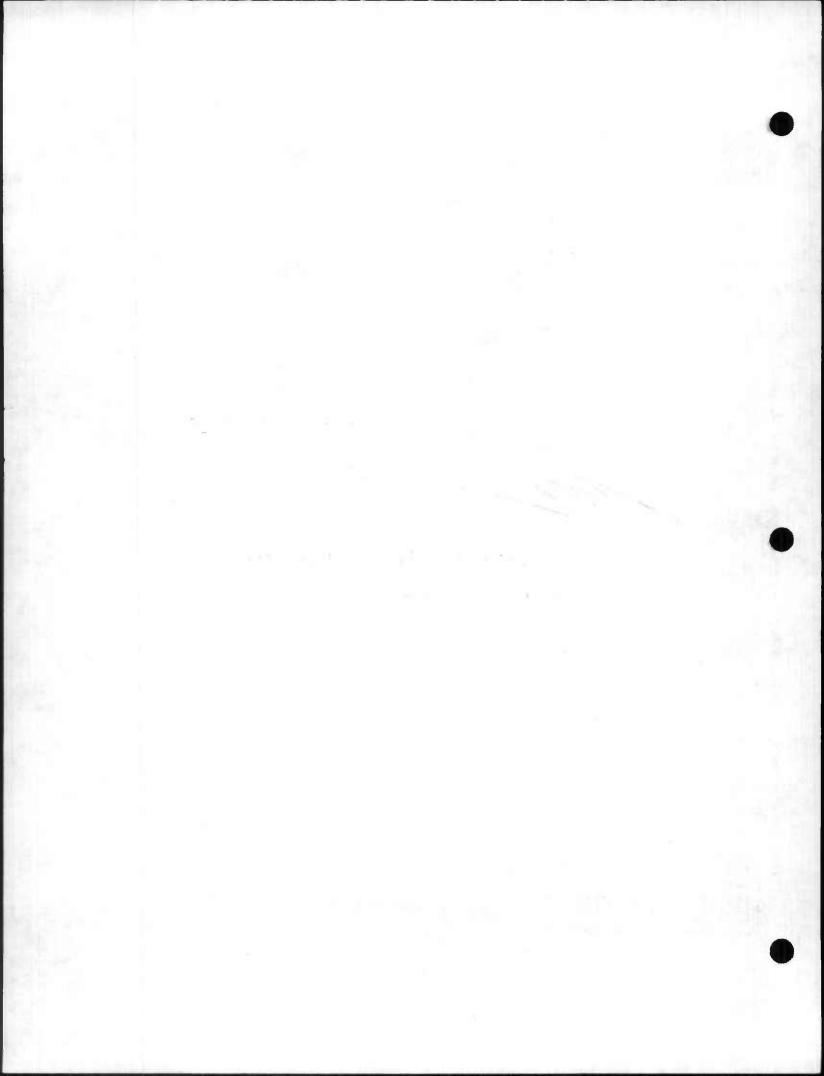
31. Date filed (Month, Day, Year) FEB 2 2, 1999



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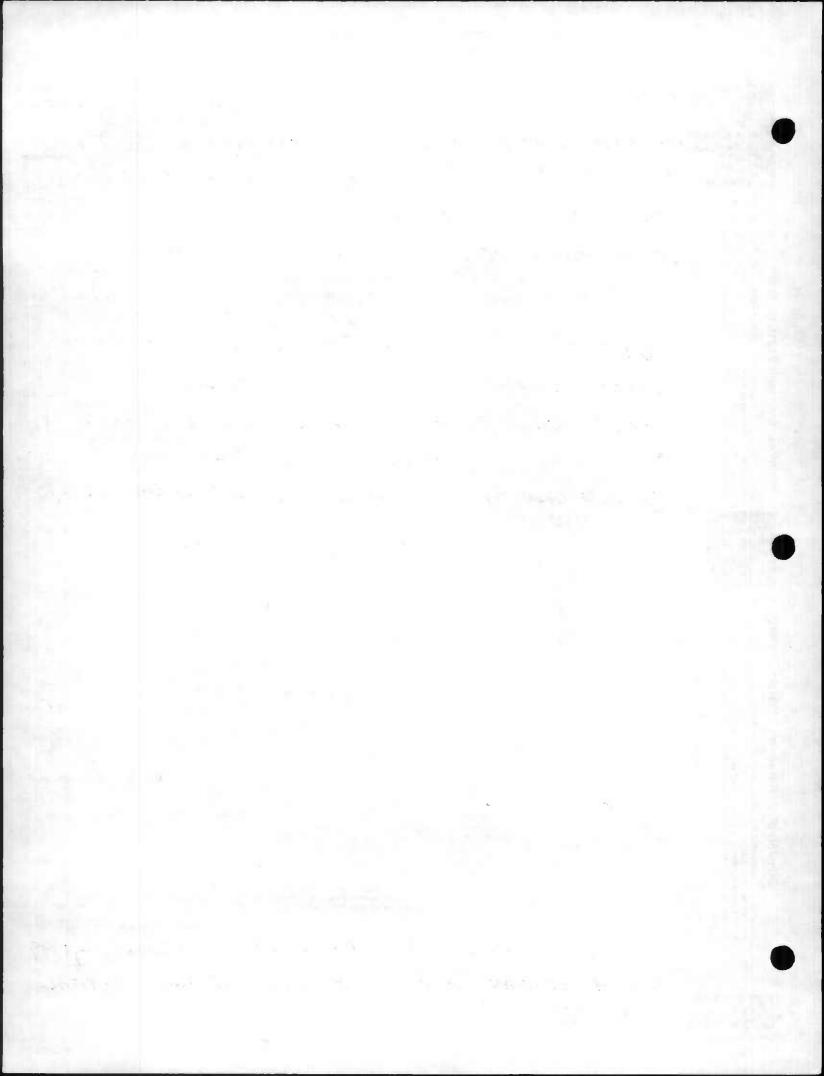
State of Maryland / Department of Health and Mental Hygiene

			Certificate of	Death	Reg	3. No. 9 9	05275					
	Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Death					
Physician /Medical	MARIE CLARA HERMANN				FEBRUAR		999 2:30 A.M					
Examiner	4s Facility Name (If not institution, give street and n	umber)		4b. City, Town, or Lo	cation of Death	4c. County of	Death					
	STELLA MARIS		THE CO.	TIMONIUM		BALTI	MORE					
Funeral	5. Social Security Number 6. Sex 1 M 2 TxF	7. Age (In yrs. last b	irthday) If Under 1 Year Months Days		8. Date of Birth (Month, Day,)	(ear)	Birthplace (State or Foreign Country)					
Director	Usuel Residence of Decedent	96	1		01/12/0	3 1	MARYLAND					
and *	10a. State 10b. County	10c. City, Tov	wn or Location				10d. Inside City Limits					
deeth with the Maryland rms 23e or 28s-f show rmst be notified at regard Director	MD BALTIMORE	CAR	NEY				1 ☐ Yes 2 ☐ No					
# 22 E	10e. Street and Number		10f. Zip Code		109	g. Citizen of Wh	at Country?					
hwi 23a	2406 LAMPOST LANE		21234	1		USA						
ifter deeth v	11. Meritel Status 12. Wes De Armed I	cedent Ever in U,S.	13. Was Decedent of If Yes, specify Cut	Hispanic Origin? (Spe	ecify Yes or No-		American Indian,					
0 0		2 No live	1 ☐ Yes 2 ☒ No		rucan, etc.)	Black, White, etc. Specify: WHITE						
ed within 72 hours at yglene. Nor than "natural", or it, the Wedical Example.	15. Decedent's Education (Specify only highest grade completed	166	Decedent's Usual Occu (Give kind of work done	pation during most of worki	na 16	Sb. Kind of Busi						
		(1-4or 5+)	(Give kind of work done life. DO NOT use retire	ed)								
s 1 and 2 should be filed within Hyglere. Health and Mentel Hyglere than 27 is marked other than other traumatic event, the MT To Be Comp	8TH GRADE		HOMEMAKER			OWN HO	ME					
d oth	17. Father's Neme (First, Middle, Last)			18. Mother's Name	e (First, Middle, Maiden Sumam							
should bent marked umarked	WILLIAM KORN		HELMO	PAULIN	E BRAUGH	EIMER						
d 2 should be file th and Mentel Hy 7 is marked other traumatic event To Be (19a. Informent's Neme/Reletionship (Type, Print)	19	b. Mailing Address (Stree	t and Number or Rura	at Route Number,	City or Town, St	tate, Zip Code)					
1 end 2 Heelth a em 27 ie	AUDREY REGNER DA	UGHTER	2406 LAMPOST	LANE CA	RNEY, MD	21234						
es 1 and of Heelth Item 27 r other tr	20e. Method of Disposition	comet	of Disposition (Name of ery, cremetory or other pla	aca)	Date 20	Oc. Location - Ci	ity or Town, State					
emit. Peges 1 el separanti. Peges 1 el separtment of Hee mportant: if item iny injury or othe	1 Burial 2 Cremetion 3 Removel from 4 Donation 5 Other (Specify)	Stere		T.	0 (00 (00	00000000						
in in it.	21. Signature of Funeral Season Licensee	DULA	NEY VALLEY N		2/22/99	COCKEY	SVILLE, MD					
permit. Peges Department of important: If is eny Injury or price.				SON FUNERA	L HOME, I	P.A.						
	23 and Pfter the disease or Complications that shoot, or heart tallura: List only one cause on		8521 LOCE	RAVEN BL	VD. TOW	SON, MD	21286 Approximate					
exacuted in and tiel-transit Examiner Examiner	Immediate Cause (Finel disease or condition resulting in deeth)	gestive Due to (or as a	neart to consequence of):	ailure								
icate be physicia s the bu	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as e consequence of): Due to (or as e consequence of):											
attendin for use	d											
ires that the deeth certification is signed by the attending diedetached for use and by Physician/Mi	Pert II. Other significant conditions contributing to	death but not resulting	iven in Pert I.	23b. Did tobacco use contribute to the cause of								
The lew requires the state has been signed page 2 should be d					24a. Wes an performe		24b. Were eutopsy findings aveilable prior to completion of cause of death?					
The la					1□ Yes	25No	1□Yes 2ELNo					
	25. Was case referred to medical			26. Place of Death	(Check only one)						
	exeminer?	Inpatient 2 EPVO	outpatient 3 DOA Ot		me 5 Residen		(Snacity)					
_ 20 _	27. Manner of Death 12 Natursl 5 □ Pending (Mo	of Injury 28b.	Time of 28c. Injury	rry et ork?	28d. Describe how							
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funer Medical Certification:	2 Accident 3 Suicide 4 Homicide investigetion M 1 Yes 2 No 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural City or Town, Stete)											
he Hospita in 24 hours he Funers pletely fille edical C	29e. Certifier (Check only one) 12 Certifying Physician: To the and ma	e best of my knowledg basis of examination en nner steted.	e, death occurred at the tind/or investigation, in my	ime, data and place, opinion, deeth occum	and due to the cau ed at the time, dat	use(s) and manne e end plece, an	ner as stated. d due to the cause(s)					
Withir Comp	29b. Signeture end title of certifier		29c. Licen	se number	290	d. Date signed ((Month, Day, Year)					
- > - 0	h 1 th	mo	10	32543		7/	18/80					
b	20. Name and address of pages 11.	, ,-		20,13		~ /	19 19 9 Beltimo-12					
600	30. Name and address of person who completed call		1 -	ni N	(1	10, (1	Baltiman					
•	MANK STROM 31. Date filed (Month, Dey, Year) 32.		0 10		Char	167 27	. MO 212					
State Registrar	FFB 2 3 1999	Registrar's Signature	B. Inc	the								
1.09.01141	FED 7. 3 1000	1	1- 10/000	4-4								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Day **Physician** FUGEN 0745 AM HOU9h /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth **Examiner** GENERAL MARYLAND BALTI MORE

If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplage (State or Foreign **Funeral** 1 M 2□ F Months Days 17207 9120 Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10b County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Md NP BattimeRE 18 Yes 2 □ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 11.5. Mc Mechen 21217 301 ST by Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married Black 1 ☐ Yes 2 ☑ No Specify: 3. Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Karlauren OWNER Kestaduran 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) permit. Pages 1 end 2 should be fi Department of Health and Mental F Important: If Item 27 is marked of FRANK Hough 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) - USENE BARRY 20e. Method of Disposition Nephew 4047 Dax to Me. 21218 The ALAMEda WISON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) any Injury or 2/25/99 workon Forest Cem 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Joseph G. Locks Sr Finent Home 130411. Centra oseph B. Rooks 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** immediate Ceuse (Finel disease or condition resulting in death) /Medical **Examiner** Examiner attanding physician end for use es the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet Initieted events resulting in deeth) Lest Due to (or as a consequenca of): that the death certificate be axed Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): 98 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Onknown signed t p 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Wes an autopsy performed? paga 2 s 2 10 No 1 Yes 1 ☐ Yes 2 ☐ No to the Hospital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Lo 1 Inpatient 2 □ ER/Outpetient 3 □ DOA After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending investigation s efter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 ☐ Homicide within 24 hours 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) end manner es steted. 29a. Certifier edicai completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALLAN GENERAL 31. Date filed (Month, Day, Year) 32. Registrer's Signeture 1999 B Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth Day Month Physician 1999 Arbella O. Hillferding February /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death c. County of Deeth Examiner Lorien Nursing Home (Riverside) Belcamp If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Yeer, Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 M 2 M F Director 234-36-4361 93 Apr.20,1905 Missouri Usual Residence of Dacadeni death with the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Baltimore Kingsville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2613 Whitt Road 21087 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Maritel Status Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: by 3 Widowed 4 Divorced White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elamantary/Secondary (0-12) Collaga (1-4or 5+) 8 yrs. n/a Assembly Line Worker Clothing Industry Department of Health and Mental Hygie important: If Nem 27 is marked other any Injury or other traumatic event, 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be end 2 should be Albert Bonar Ella Eddy 19a. Informent's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Mr. Lloyd Hillferding 2613 Whitt Road Kingsville, Maryland 21087 Pages 1 20b. Place of Disposition (Neme of cametery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) BelAir Memorial Gardens 2/19/99 BelAir, Maryland 21014 21. Signature of Funeral Servica Consee 22. Name end Address of Facility E.F.Lassahn Funeral Home 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest,

Approximete shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth **Physician** dey Immediata Causa (Finel disease or condition resulting in daath) /Medical Examiner Due to (of as e consaquanca of) week Examiner vernous ci physician end the bunal-transit the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Causa (Disaasa or Injury that initieted events resulting in death) Lest Due to (or es e consequence of): Records, P.O. Box 68760 Physician/Medical Due to (or es e consequenca of): 98 ettending (ed by the e Pert II. Other/significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by t 1□ Yes 2☑No 3 Probably 4 Unknown p 24b. Were eutopsy findings eveileble prior to completion of cause of daeth? 24e. Was an autopsy performed? Completed peed certificate has 1 🗆 Yes 1 ☐ Yes 2 ☐ No Division of Vital funeral director, 25. Was case referred to medical exeminar? Be 26. Placa of Daath (Check only ona) 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28a. Data of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? Atter Naturei 5 Pending or Attending efter death. Director: Att 1 Yes 2 No 2 Accident Investigation 3 ☐ Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) filled in by 4 Homicide To the Hospital c within 24 hours e' To the Funeral D completely filled Medical 29a. Certifier 🗠 Certifying Physician: To the best of my knowledga, death occurred et the time, dete end pleca, end due to the cause(s) end mennar es stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner steted. 29c. License number 29b. Signature and title of 29d. Date signed (Month, Dey, Year) FACE

as of person who completed cause of deeth (Itam 23e) (Type, Print)

32. Registrer's Signeture

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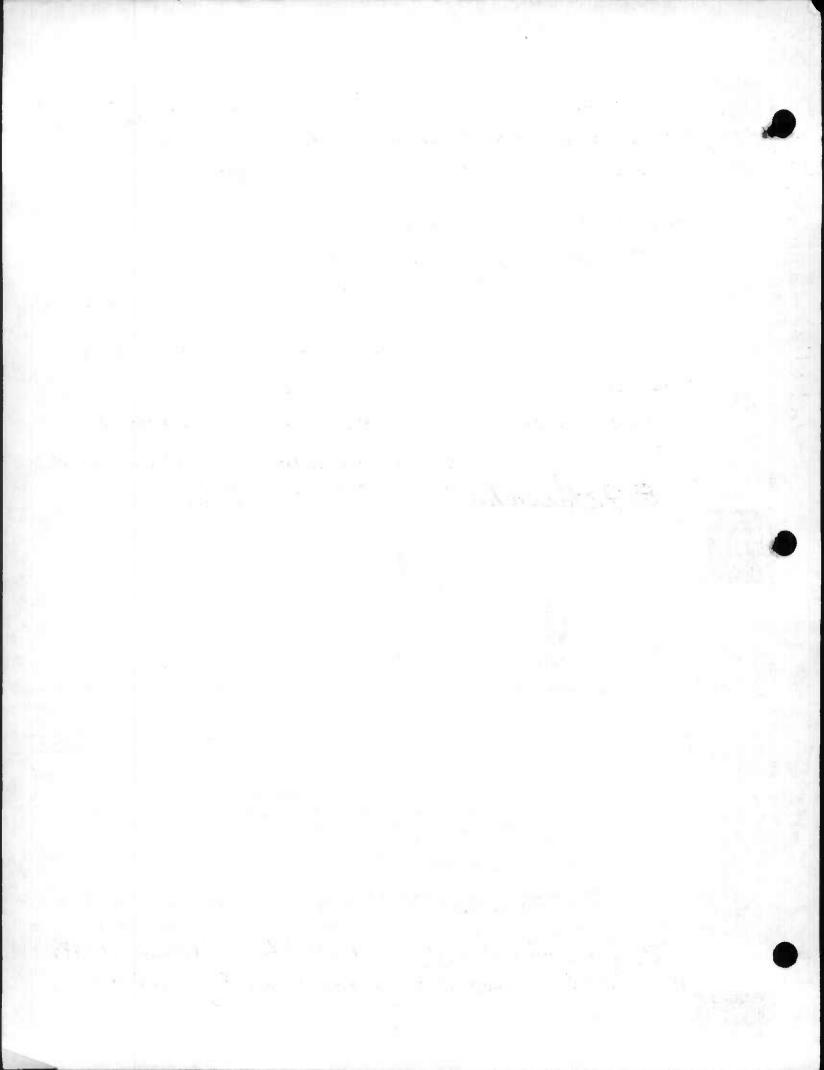
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Please Type or Print in Biack Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Dete of Death 3. Tima of Death 10 56 pm Month Day Vaar **Physician** Thomas Hill tebruary 1999 20 /Medical 4a Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore General Hospital lary land 8. Date of Birth (Month, Day, Year) Apr 16, 1957 If Under 24 Hrs. 6. Sex 1 M 2 F If Undar 1 Yaar 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Days Min Months. 41 Hours MD 215-70-6704 Director Usual Rasidance of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. Stata 10b. County / is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Y□ Yas 2□ No MD Director N.A Baltimore 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code 21205 United States 919 N. Luzerne Street Funeral 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexicen, Puarto Ricen, atc.) 12. Wes Dacedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No 11 Marital Status 14. Rece - American Indian, Black, Whita, atc. nit. Pages I and 2 should be filed within 72 hours after of nerment of Heelth and Mental Hygiena. ortant: If item 27 Is marked other than "natural", or ite Injury or other traumatic event, the Medical Examina Y Nevar Merried 2 Married 1 ☐ Yas Z☐ No Specify: by Black 3 □ Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Home Improvement Elementary/Secondary (0-12) College (1-4or 5+) Laborer 18. Mothar's Nama (First, Middla, Maidan Surnama) 17. Fether's Name (First, Middle, Last) Be Florence Hill Burley Taylor 19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 719 N. Luzerne Street, Baltimore, MD 21205 Mr. Daniel Clay (Brother) 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20a. Mathod of Disposition Feb 25 20c. Location - City or Town, Stata Burial 2 Cremetion 3 Removel from State Baltimore, MD 4 Donation Mount Zion Cemetery 1999 5 Othar (Specify) 21. Signature of Juperal Service Licensee 22. Nama and Addrass of Facility Calvin L Williams Funeral Service allen d. 270 Fredhilton Pass Baltimore, MD 23a. Pert1. Entar the disease, or complications that ceused the deeth. Do not entar the mode of dying, such as cerdiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** /Medical Hemorrhagic Immediata Causa (Final disaasa or condition rasulting in death) Examiner Dua to (or as a consequence of) Examiner ettanding physician end for use as the buriel-trensit tha death certificate be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated avents resulting in death) Last Due to (or as a consequence of): Physician/Medical Dua to (or as a consaquance of): ed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed t b 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? Completed complation of cause of death? certificata has b lirector, page 2 s Thei 1 Yas 2 No 1 Yas 2 No Physician: 25. 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(Specify) 4 Homicida To the Hospital c within 24 hours at To the Funeral D completely filled 1 Certifying Phyalcian: To the best of my knowledge, daath occurred at tha tima, dete end place, end due to the cause(s) and menner es stated. 2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Cartifier Medical (Check only one) 29d. Data signed (Month, Day, Year) 29c. Licansa number 29b. Signature end title of certifia 20,

State Registrar

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

P.O. Box 68760.

Division of Vital Records,

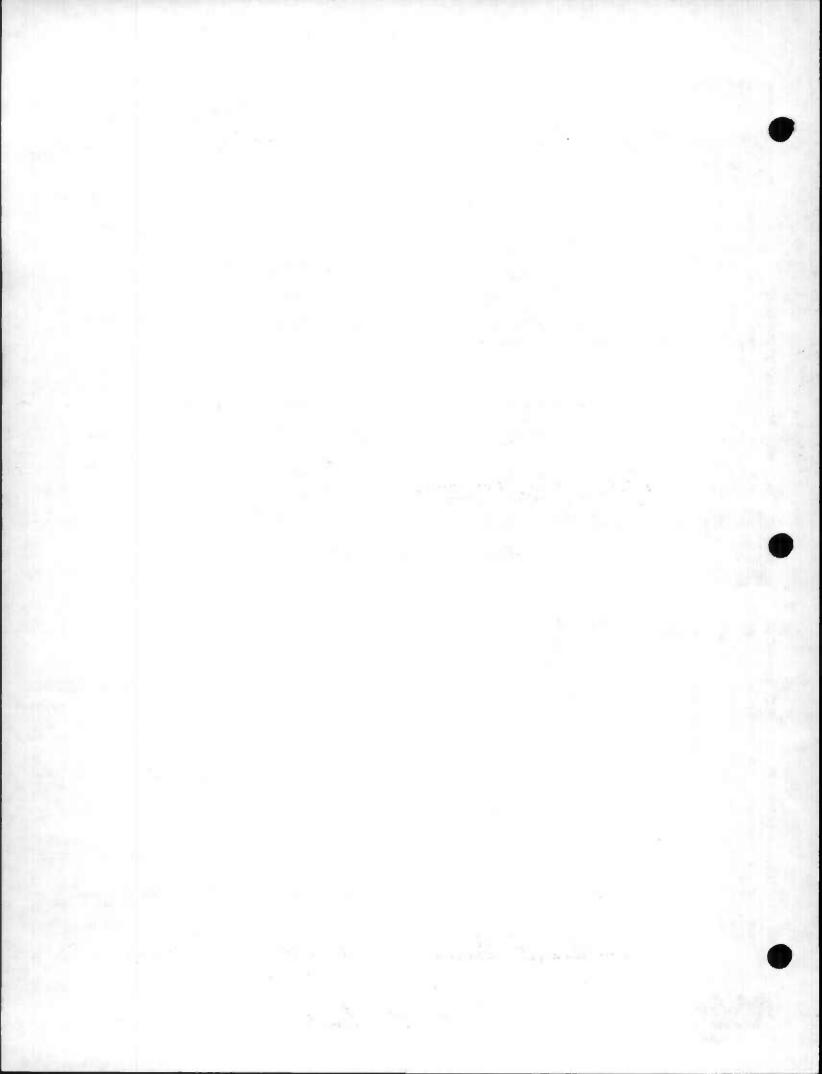
homas

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32. Ragistrar's Signatura

30. Name and eddress of person who completed cause of death (Itam 23a) (Type, Print) Jose Garcia, M. D. To Maryland G

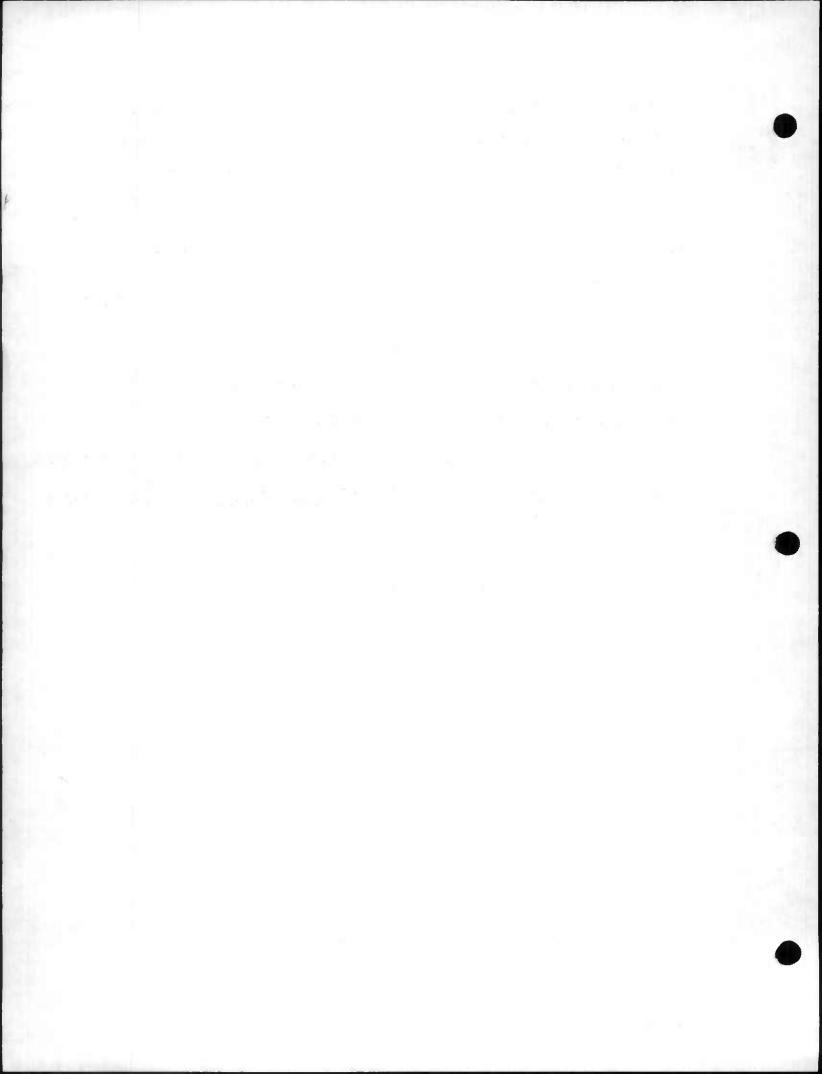
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State of Maryland / Department of Health and Mental Hygiene

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5 00	7	1 Yes 2 No 27. Manner of Deeth	-		ER/Outpatien	t 3 DOA	ther: 4 ☐ Nursing	Home 5 Reside			(v)
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#31 perDVR G768 2/23/99EW Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Jacobson **Physician** 17:15 sau /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c County of Deeth Examiner DWGV (or nera olunbi DWave If Under 1 Year Dete of Birth (Month; Day, 5. Social Security Number In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** Days 10 M 20 F 3355 28 OKLAHOMA Yes Director Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 □ No HOWARD COLUMBIA Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21045 9433 DIAMONDBACK DRIVE U.S.A. Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mentel Hyglene. Important: if Itam 27 le marked other than "naturel", or he early injury or other traumatic event, the Medical Examine Dica. 1 Tyes 2 No WW II
Wes, Give
Year or Dates: 1 Never Married 2 Married Specify: WHITE Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) WATCHMAKER TEWELRY. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 ANNA **JACOBSON JACOBSON** SAMUEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 205 DELIGHT MEADOWS RD. REISTERSTOWN MD 21136 BARRY JACOBSON /SON 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cometery, crematory or other place)
DULANEY VALLEY MEMORIAL
GARDENS 1 Burial 2 □ Cremetion 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/19/99 TIMONIUM MD 22. Name end Address of Fecility SOL LEVINSON & BROS. 21. Signature & Funeral S 8900 REISTERSTOWN ROAD PIKESVILLE MD 21208 X.P or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximete Intervel Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Box 68760. The law requires that the death certificate be Due to (or as a consequence of): 080 P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown by Records. 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en autopsy Be Completed page 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vitai 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitat: 1. Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA edicai Certification: To After this 28c. Injury et Work? 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28d. Describe how injury occurred Division or Attanding s efter de. 1 DNatural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital 24 hours 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier

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State Registrar 31. Date filed (Month, Day, Year)

Wheen

29b. Signature and title of certified

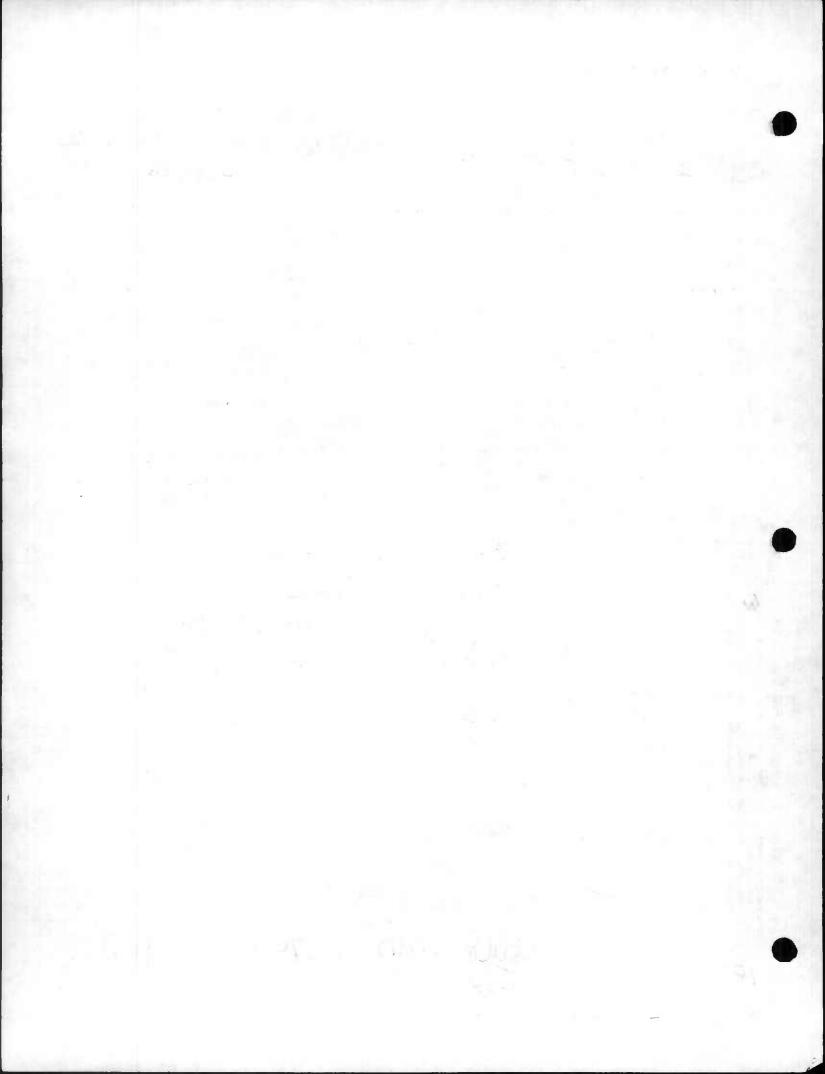
time 32. Registrar's Signature 1999 EB 23

29c. License number

29d. Date signed (Month, Dey, Year)

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To the Hosp within 24 hou To the Fune completely fi



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** Ebruar .12 /Medical 4c. County of Deeth 4e Feeility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner 105pita 7. Age (In yrs. lest birthdey) 72 Yrs. 5. Sociel Security Number Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M 210 F Months Deys Hours Min. Director 281-20-0986 Ohio Usuel Residence of Decedent deeth with the Meryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified at MD 1 ☐ Yes 2 No Anne Arundel Severna Park Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21146 USA 8 Ridout Road Funeral r than "natural", or items in the Medical Examiner ma 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes Z☐ No if Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, 11. Meritel Status Bleck, White, etc. filed within 72 hours efter 1 ☐ Never Married 2 ☐ Married specify: White 1 Yes 2 No Specify: þ Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) I Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Realtor Real Estate nit. Peges 1 end 2 should be filed entment of Heelth end Mental Hygi ortant: if item 27 is marked other Injury or other traumatic event, I 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Wilhelm Buergel Maria Hermes 19a. Informent's Name/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 390 Grace Ridge Dr. Sandra N. Daiger/daughter Lancaster, PA 17601 Baltimore. 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 Oremation 3 Removel from State permit. Pege Depertment of Important: If any Injury or Metro Crematory, Inc. 02/23/99 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Lice 22. Name end Address of Fecility A Cremation Society of Maryland, Inc. dur neh Edward A regorchik 299 Frederick Rd. Balt: 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on eech line. Edward 299 Frederick Rd. Baltimore, MD 21228 Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final diseese or condition resulting in death) **Examiner** Examiner physician end the buriel-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Last Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequenca of): 80 USB Po Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? ed by the 2 No 3 Probably 4 Unknown signed b þ 24b. Were autopsy findings eveilable prior to page 2 should Completed 24a. Wes en autopsy peen performed? completion of cause of deeth? certificete has 2 12 NO 1 □ Yes 2 □ No 1 Yes Hospital or Attending Physician: director. 25. Wes case referred to medical Be 26. Place of Death (Check only one) exeminer? 1 Yes 2 No Hospital: 1 Inpatient 2 □ ER/Outpetient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this funeral 27. Manner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred Certification: After 1 Natural
2 Accident 5 Pending investigation s efter death. 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) filled in by 4 Homleide 24 hours Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the bests of examination end/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner steted. To the Hospi within 24 hou To the Funer completely fil Medicai 29a. Certifier (Check only one) 29b. Signature end title of cartifier 29c. License number 29d. Date signed (Month, Dev. Yeer) 5307 30. Neme and eddress of pe cause of deeth (Item 23e) (Type, Print) Johns

DHMH 16 Rev 6/95

State

Registrar

31. Dete filed (Month, Day, Year)

1999

32. Registrer's Signature

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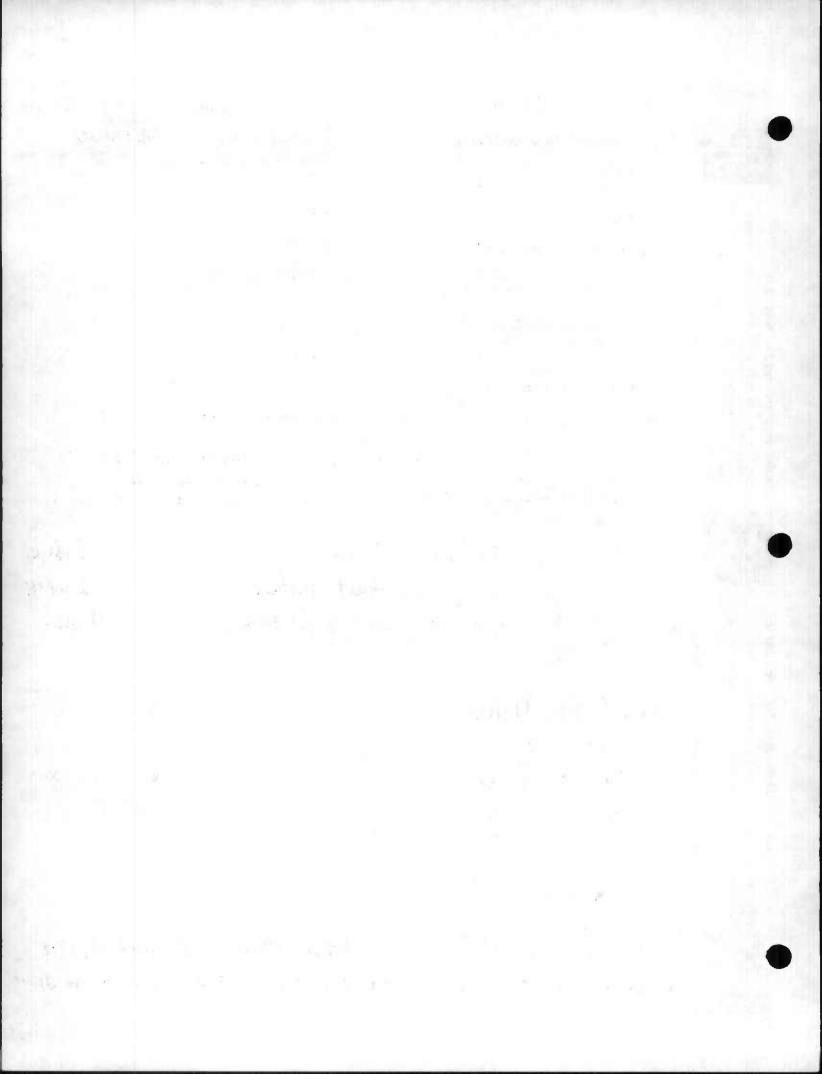
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 5 5 2 8 2 Certificate of Death Reg. No.

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P	Physician	1. Decedent's Neme		TSCH					2. Date of De Month	eath Dey	Year 1999	3. Tima of Death	
	/Medical Examiner	4a Facility Name (If	1 44		-)			4b. City, Town, or	FEBRUAR Location of Deet		ounty of Death		
	LXammer	GOOD SA	MAR ITA	V HOSPIT	AL			BALTIN	nore	BAL	KTIMORE		
	Funeral Director	5. Social Security Nu 214-03-16	37	7. A	ge (In yrs. lest I 84		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th, Year 1914	9. Birthp Coun Man	lace (Stete or Foreign try) cyland	
	w.	Usual Residence of I	10b. County		10c. City, To	wn or Loca	tion				1	Od. Inside City Limits	
	death with the Maryland me 23e or 28e-f show Linust be notified at	Maryland	N/A				Baltin	nore				1 Yes 2□No	
	or 28s	10e. Street end Num					10f. Zip Code	1000		10g. Citizen of V	Vhat Coun	itry?	
	23a c	5905 1	Ayleshi	re Road				L239		US			
21215-0020	or setter	11. Marital Status 1 Never Marrie 3 Widowed 4	2.2	12. Was Deceden Armed Forcas 1 Types 2 If Yes, Give Year or Dates	? INO WUTT	If Yas, specify Cuban, Maxican, Puerto Rican, etc.) Black, White							
5-0	be filed within 72 hould list Hygiena. If other than "nature ovent, it is received.	(Specif	15. Decedent's Edit y only highest grad	cetion le completed)	16a. Decedent's Usuel O (Give kind of work of life. DO NOT use r			etion during most of wa	orking	16b. Kind of Bu	ısiness/Ind	dustry	
121	within than " than " comple	Elementery/Secon		College (1-4or	5+)					IIC Dos	. t o 1	Service	
	e filed within the hygiene. other than vent, the hygiene.	12. Tather's Name (F	irst, Middle, Last)			ret	ter Ca		me (First, Middle	, Melden Sumer		pervice	
lan	should be no Mental marked o imatic eve	Georg	ge Kaut	sch				Li	llian	Daniels	5		
Maryland	200	19a. Informant's Name/Relationship (Type, Print) Jane A. Kautsch/wife 19b. Malling Address (Street end Number or Rural Routa Number, City or Town 5905 Ayleshire Road Baltimore, MD											
	permit. Peges 1 end Department of Health Important: if item 27 any injury or other tr once.	Jane A. 20a. Mathod of Dispe		- City or Town, State									
nor	Peges ent of I nt: If Ite ry or o	1 □ Burial 2 ☑	Cremation 3 □		ceme	tery, creme	ion (Neme of tory or other ple		Date 2/20/99	Balti			
Baltimore	permit. Peg Department Important: if any injury o	21. Signatura of Fup	oral Service Licens		Metro		natory,						
B	Depa Impo	D.	DIMINO	TAME	mald	Cr. 29	ematio 9 Fred	ss of Eacility n Socie erick R	ty of	Marylar altimor	nd, . re.]	Inc. MD 21228	
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		resulting in deetily		Car	Due to (or es	e conseque	ence of):	Foilure				1 wpok	
	axecuted n end ial-transit	Sequentially list con-	ditions,	b. COI	A	e conseque	nce of):	D.				I WILL	
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	death e etta ed for	Part II. Other signific	ant conditions co	ntributing to death	but not resulting	in the und	erlying ceuse giv	ven in Pert I.	23b. Did	tobacco use co	ntribute to	the cause of death?	
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Records,	w 2 € 0	Prosto	ate C.	a		16			24e. Was	s en eutopsy omed?	ev	ere autopsy findings eileble prior to mpletion of cause deeth?	
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of Vital	this cral dire	1 ☐ Yes 2 N 27. Manner of Death	0	Hospital: 1 Inpa		Outpatient o. Time of	3□ DOA Ott	4 LI Nursing	_	how injury occur	-	y)	
9	Attending Physician: or death. octor: After this cartific by the funeral director,	1 Natural 2 Accident	5 Pending investigation	28e. Date of In (Month, D	ay Year)	Injury	28c. Injul Wo M 1	k? Yes 2□No	200. 0000.00	now injury cooks			
Division	after daa Director d in by the	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory building, etc. (Specify)										el Route Number,	
	To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this cartificate he completaly filled in by the funeral director, paga Medical Certification: To Be Com	29a. Certifiar (Check only one)	Certifying Phy Medical Exam	sician: To the bes ner: On the basis and menner:	of examination e	ige, death o end/or inves	ccurred at the tis stigation, in my o	me, date and plec pinion, deeth occ	e, and due to the surred at the time	cause(s) and ma date end piece,	nnar as s and due to	teted. o the cause(s)	
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	1	30. Nemb end eddress of person who samplified ceuse of deeth (Item 23e) (Type, Print) WION MEMORIAL HOSPITAL 201 EAST UNIVERSITY PKWY BALTIMORE								FEBRUA	4 10	9, 1999	
	5	30. Neme end eddres	ss of person who	implified ceuse of		(Type, Pr	int)	IEDO AL V	DV. V D	y Da-ne	MARI	VIA.ID 11118	
0	State	31. Dete filed (Month	Day, Year)	32. Regis	ITAL 2 trer's Signature	UIB	BI UNIV	03117	KWI G	TUTTIOKE	I MPH-	MIND SIKIO	

DHMH 16 Rev 6/95

Registrar

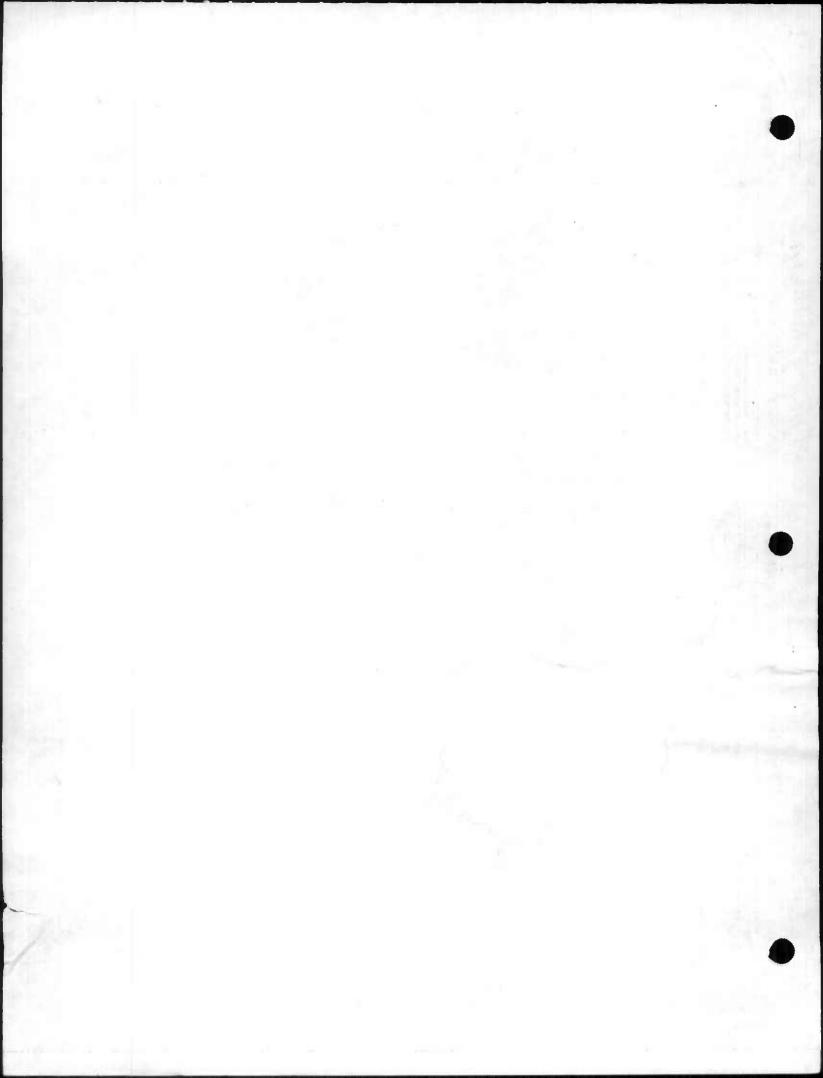


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middle, Last) 2. Data of Death Month Day **Physician** 2:25 MM Kelly Roberta TEBRUARY (4,1) /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 46 County of Death Examiner Stella Maris Mercy Baltimore If Under 1 Year 7. Aga (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Min. 1□M 20F Months Hours Director 240-36-0759 04 04 N.C 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits ms 23s or 28s-f sh cmust be notified a 1 XYes 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? Berns 23s or 1742 Moreland Ave 21216 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yas 2 XNo If Yas, Giva 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 ☑ No Specify: altimore, Maryland 21215-0020 å 3 Widowed 4 Divorced Year or Dates: Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Uspartment of Health and Mental Hygiens. Important: If flow 27 is merised other tran "natuanty injury or other traumatic aware tran "natuants." 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Beautician yrs. Beauty Salon 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Be Lonnie Miller Loveann McNeely 19a. tnformant's Name/Ratationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6925 Wolf Run Drive Charlotte, N.C. 28
se of Disposition (Name of Data 20c. Location - City or Town, State Mac Arthur Kelly-Son 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Loudon Park Cemetery2/20/99 Baltimore, Md 21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Facility March F/H West 4300 Wabash Ave, lade Women Baltimore Md 21215 23a. Part1. Entar tha disease or complications that caused the death. Do not antar the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death Physician Adenouvinon /Medical Immediate Causa (Final My-troops to 3 moush disaasa or conditior rasulting in death) Examiner Dua to (or as a consequence of) death certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaasa or Injury that initiated avants rasulting in daath) Last and Dua to (or as a consequance of): physician Box 68760 Physician/Medical the Dua to (or as a consequance of): USB &\$ P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 8 Completed 24a. Was an autopsy 24b. Wara autopsy findings available prior to completion of ceuse of death? The law certificate 1□ Yes 2 No 1 Yes 2 No Division of Vital or Attending Physician: 25. Was casa rafarred to medical axaminar? Be Maris At Mekey 26. Place of Death (Check only one) Stella Hospitat: Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Certification: To 1 Yas 2 No 1 inpatiant 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Data of tnjury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred 5 Pending invastigation Naturat injury after death.

I Director: After its full of the full o 1 Yas 2 No 2 Accident 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida filled in To the Hospital of within 24 hours of To the Funeral D completely filled it Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar Medical (Check only one) 29b. Signature and titla of certifiage 29c. Licensa number 29d. Data signed (Month, Day, Year) D40854 16/49 30. Name and addrass of person who complated ceusa of death (Item 23a) (Type, Print) Risebers Pul PI Bultinon 21202 Varie 301 31. Date filed (Month, Fax 18 3 19932. Registrar's Signature State Registrar



Funeral Director with the Maryland r 28a-f show show

atricia

7 is marked other than "natural", or items 23s or traumatic event, the Mou cal Examiner must be a permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mantal Hygiena. Insportant: If item 27 is marked other than "natural", or items 23. altimore, Maryland 21215-0020 Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middla, Last) Charles William Endley Sr. 19a. Informant's Name/Ralationship (Type, Print) Lawrence Kluka (Husband) Important: If item 27 any injury or other to page. 20b. Place of Disposition (Name of 20a. Mathod of Disposition 1 N Burial 2 ☐ Crametion 3 ☐ Ramovel from State Druid Ridge Cemetery 4 Donation 5 Othar (Specify) 21. Signature of Funeral Service Licensee 23a. Part. Enlar the disease, or complications that codsed the death. Do not enter the mode of dying, such es cardiac or respirelory errest, shock, or heart failure. List only one ceuse on each line. **Physician** /Medical Immediata Causa (Finel diseasa or condition resulting in death) neumonia Examiner Dua to (or es a consequança of): Physiclan/Medical Examiner The law requires that the death certificate be executed attanding physician and for usa as the burial-transit Sequentially list conditions, if any, laeding to immediata causa. Entar Underlying Causa (Diseasa or Injury that initiated evants Dua to (or es a consaguance of): Division of Vital Records. P.O. Box 68760. organ rasulting in death) Last signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No þ been signated 24e. Wes an autopsy performad? Completed cartificata has t 1□ Yes 2 No or Attending Physician: director. Be 25. Was casa rafarrad to medical axaminar? 26. Pieca of Daath (Chack only ona) 1 Yas 2 No 10 1 1 Inpatiant 2 ☐ ER/Outpalient 3 ☐ DOA this 28a. Deta of Injury (Month, Day Year) funaral 27. Mennar of Death 28b. Time of 28c. Injury at Work? Certification: Aftar 1 Naturel 5 Panding 1 Yas 2 No invastigation aftar daath. Director: A 2 Accident 6 Could not be datamined 3 ☐ Suicide 28a. Place of injury - At home, farm, straat, factory, office building, atc. (Spacify) in 24 hours Funeral Directifiled in by 4 Homicide Hospital 29a. Cartifier Medical complataly (Check only one) within 2 29b. Signatura and titla of offiting 29c. Licensa number 18

32. Registrer's Signatura

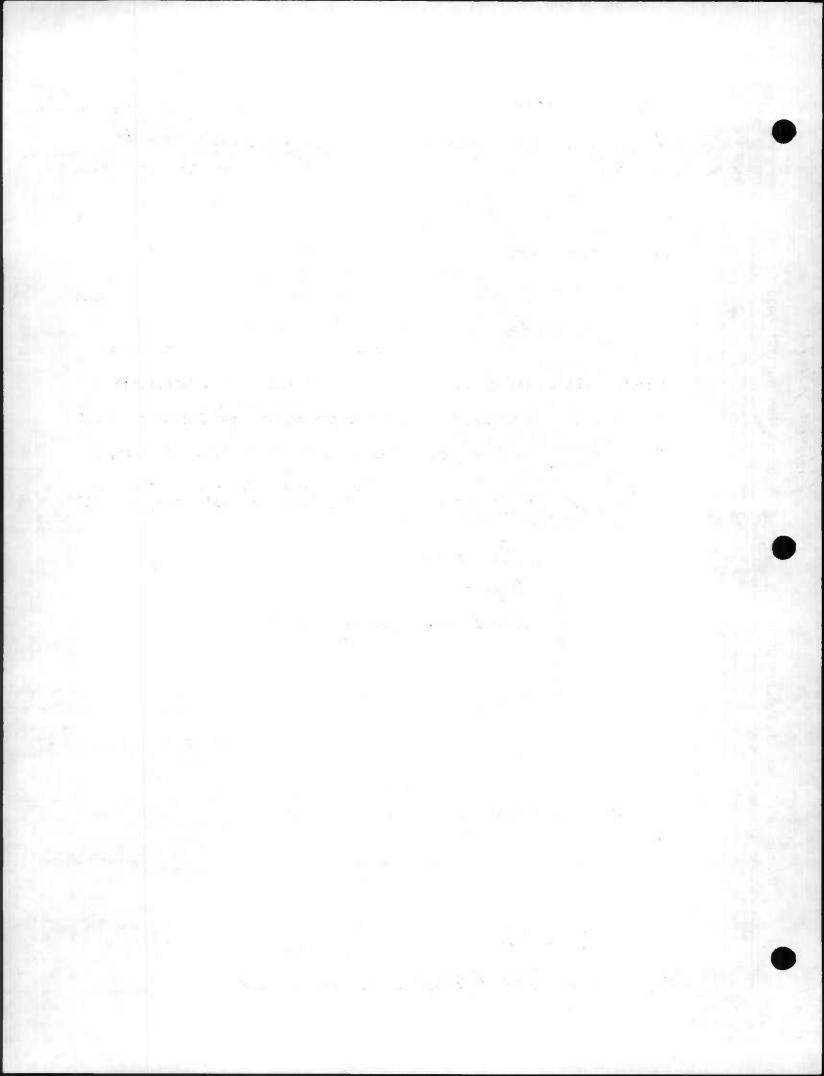
Certificate of Death 01 3. Time of Deeth 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3 40 Day Vear Month **Physician** Am PATRICIA ANN KLUKA 1999 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give straat and number) Examiner Ba Himore
If Under 1 Year If Undar 24 Hrs. 8 City General n/a Hospita lary land 8. Data of Birth (Mooth, Day, Y 5. Social Sacurity Number 7. Age (Ih yrs. last birthday) 9. Birthplaca (Stata or Foreign Months Days Hours 10 M &F F Maryland 215-46-7193 54 Usual Rasidance of Dacedant 10d. Inside City Limits 10e State 10b. County 10c. City, Town or Location Yes 2 No n/a Baltimore Director 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 1507 Clarkson Street 21230 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas ※☐ No If Yas, Giva Year or Detas: 13. Was Decedant of Hispanic Orlgin? (Specify Yes or NoIf Yas, specify Cuben, Maxican, Puerto Rican, atc.)

1 ☐ Yas 2 ☐ No Specify: 14. Race - American indien, Black White etc 1 Navar Marriad 2 Married white Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usuel Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grada complated) Home Owner 18. Mothar's Nama (First, Middla, Maidan Sumama) Virginia Rita Heisterman 19b. Mailing Address (Straat and Numbar or Rural Route Number, City or Town, Stata, Zip Code) 1507 Clarkson Street, Baltimore, Md. 21230 20c. Location - City or Town, Stata 2/22/99 Baltimore, Md. 22. Nama and Address of Facility
McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave. Baltimore, Md. 21230 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 □ Unknown 24b. Wara autopsy findings aveileble prior to complation of cause of death? 1 Tyes 2 TNo Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 28d. Dascribe how injury occurred 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and dua to the cause(s) end menner as steled.
2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, data end place, end due to the cause(s) end menner stated. 29d. Data signed (Month, Day, Year) 99 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Ana Sarante, M.D., To Maryland G Sarante

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 16 Rev 6/95

State Registrar 31. Data filed (Month, Day, Year) FEB 2 3 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item: 26 per M.D G-768 2/23/99 reb Reg. No. Certificate of Death 3. Tima of Deeth 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death 17, 1999 8:45 P.M. February Frances Koch 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, giva streat and number) Brooklyn 18 Thomas Ave. Anne Arundel If Under 1 Year | If Undar 24 Hrs. 8. Dete of Birth (Month, Dev. Year) Birthplece (State or Foraign Country) 5. Sociei Security Number 7. Age (In vrs. last birthdey) 1□ M 2 F Months Days Hours Min Yrs. 78 219-14-0774 Dec. 23, 1920 Maryland Usuei Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Md. Anne Arundel Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 18 Thomas Avenue 21225 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Giva Year or Detas: 14. Reca - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 11. Marital Status 1 Never Married 2 Merried 1 Yas 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) 8th 0 Homemaker 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) August Strauss Eleanor Williams 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 18 Thomas Avenue Baltimore, Maryland 21225 John Vincent Koch (Husband 20b. Plece of Disposition (Nema of cemetery, cremetory or other place) 20e. Method of Disposition

1 Dauriel 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Othar (Specify) Glen Haven Memorial Park 2/22/99 Glen Burnie, Maryland 22. Name end Addrass of Facility
McCully-Polyniak Funeral Home P.A. 21. Signature of Funeral Sarvice Licensee Kevin E. Ecker 237 E. Patapsco Avenue Baltimore, Maryland 21225 Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Final disease or condition resulting in deeth) ues Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Pert I. ne 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveileble prior to complation of causa of death? 24e. Wes en eutopsy performed? ever py 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was cese referred to medical exeminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 28d. Describe how injury occurred 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of Work?

/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Box 68760. as signed by the a Division of Vital Records, P.O.

Physician

/Medical

Examiner

Funeral

Director

th and Mental Hygiene.
7 is marked other than "naturel", or items 23s or 28s-f show treumstic event, the Medical Exercitor must be notified at

Item 27 is other tra

Physician

Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.

Saltimore, Maryland 21215-0020

death with the Maryland

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10a. Stata

Directo

Funeral

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Completed

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Certification:

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1 Naturei

2 Accident

3 ☐ Suicide

29a. Certifian

4 Homicide

(Check only one)

31. Data filed (Month,

29b. Signature and title of contil

been si ate has b director, pag or Attending Physician: After this funeral aftar death. Director: A To the Hospital or A within 24 hours aftar To the Funeral Directompletely filled in by

> State Registrar

se of death (Item 23e) (Type, Print) 30. Name and eddress of pe

5 Pending Investigation

6 Could not be determined

29c. Licensa number

2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred et the time, dete end place, end due to the cause(s) end menner stated.

14 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, end due to the ceusa(s) end menner es steted.

1 Yes 2 No

29d. Date signed (Month, Day, Year)

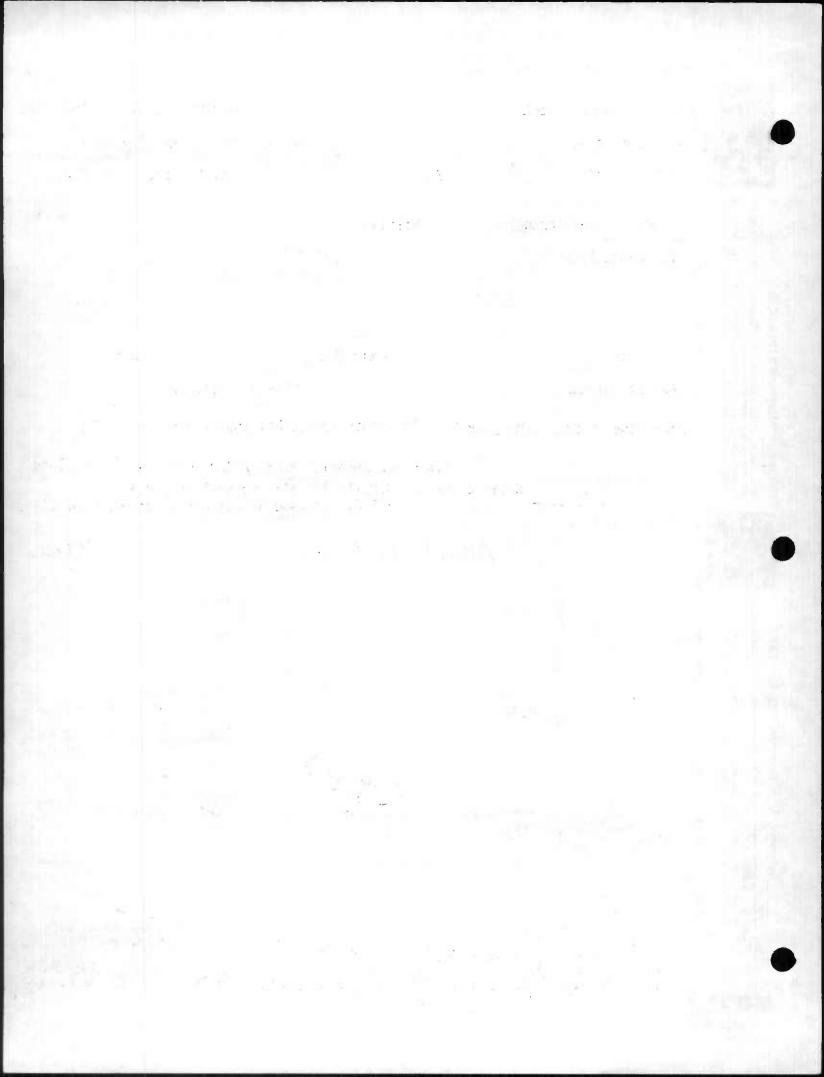
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

106

784r

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

32. Registrer's Signatur



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

46 City, Town, or Location of Death PIKESVILLE NURSING HOME 213-36-9539 1 M MXF 7 Age (in yrs. sart birtholay) 8 Under 1 Year 2 213-36-9539 1 M MXF 7 Age (in yrs. sart birtholay) 8 Under 1 Year 2 213-36-9539 1 M MXF 7 Age (in yrs. sart birtholay) 8 Under 1 Year 2 213-36-9539 1 M MXF 7 Age (in yrs. sart birtholay) 8 Under 1 Year 2 213-36-9539 1 M MXF 7 Age (in yrs. sart birtholay) 8 Under 1 Year 2 213-36-9539 1 M MXF 7 Age (in yrs. sart birtholay) 8 Under 1 Year 2 213-36-9539 1 M MXF 7 Age (in yrs. sart birtholay) 8 Under 1 Year 2 213-36-9539 1 M MXF 7 Age (in yrs. sart birtholay) 8 Under 1 Year 2 213-36-9539 1 M MXF 7 Age (in yrs. sart birtholay) 8 Under 1 Year 2 213-36-9539 1 M MXF 7 Age (in yrs. sart birtholay) 8 Under 1 Year 2 213-36-9539 1 M MXF 7 Age (in yrs. sart birtholay) 8 Under 1 Year 2 210 M MXF 7 Age (in yrs. sart birtholay) 8 Under 1 Year 2 210 M MXF 7 Age (in yrs. sart birtholay) 8 Under 1 Year 2 210 M MXF 7 Age (in yrs. sart birtholay) 8 Under 1 Year 2 210 M MXF 7 Age (in yrs. sart birtholay) 8 Under 1 Year 2 210 M MXF 7 Age (in yrs. sart birtholay) 8 Under 1 Year 2 210 M MXF 7 Age (in yrs. sart birtholay) 8 Under 1 Year 2 210 M MXF 7 Age (in yrs. sart birtholay) 8 Under 1 Year 2 210 M MXF 7 Age (in yrs. sart birtholay) 8 Under 1 Year 2 210 M MXF 7 Age (in yrs. sart birtholay) 8 Under 1 Year 2 210 M MXF 7 Age (in yrs. sart birtholay) 8 Under 1 Year 2 210 M MXF 7 Age (in yrs. sart birtholay) 8 Under 1 Year 2 210 M MXF 7 Age (in yrs. sart birtholay) 8 Under 1 Year 2 210 M MXF 7 Age (in yrs. sart birtholay) 8 Under 1 Year 2 210 M MXF 7 Age (in yrs. sart birtholay) 8 Under 1 Year 2 210 M MXF 7 Age (in yrs. sart birtholay) 8 Under 1 Year 2 210 M MXF 7 Age (in yrs. sart birtholay) 9 Under 1 Year 2 210 M MXF 7 Age (in yrs. sart birtholay) 9 Under 1 Year 2 210 M MXF 7 Age (in yrs. sart birtholay) 9 Under 1 Year 2 210 M MXF 7 Age (in yrs. sart birtholay) 9 Under 1 Year 2 210 M MXF 7 Age (in yrs. sart birtholay) 9 Under 1 Year 2 210 M MXF 7 Age (in yrs. sart birtholay) 9 Under 1 Year 2 210 M MXF 7 Age (in	0 5 2 8 6									
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Social Scuriny Number 213-36-9539 1 M XF 7. Age (in yes, last printary) 8 M yes Months Days Hours Mn. MAY 279 1010	IORE									
10e. Street and Number 10e. City, Town or Location PIKESVILLE	Birthplece (Stete or Fo									
MD BALTIMORE PIKESVILLE 10. Ze Code 10. Citize and Number 7 SUDBROOK LANE 10. Was Decedent Ever in U.S. 13. Was Decedent of Hispenic Origin? (Specify Yes or No. 1. U.S. A.* 14. Rea Black Status 10. Never Married 2 Married 3 Windows 4 1 Divorced 10. New Forces 10. S. A.* 13. Was Decedent of Hispenic Origin? (Specify Yes or No. 1. U.S. 2. Was Decedent Ever in U.S. A.* 13. Was Decedent of Hispenic Origin? (Specify Yes or No. 1. U.S. 2. Was Decedent Ever in U.S. A.* 14. Rea Black Status 10. Never Married 2 Married 3 Windows 4 1 Divorced 10. New Force Married 2 Married (Specify only highest grade completed) 10. New Force Married (Specify only highest grade completed) 10. New Force Married (Specify only highest grade completed) 10. New Force Married (Specify only highest grade completed) 10. New Force Married (Specify only highest grade completed) 10. New Force Married (Specify only highest grade completed) 10. New Force Married (Specify only highest grade completed) 10. New Force Married (Specify only highest grade completed) 10. New Force Married (Specify only highest grade completed) 10. New Force Married (Specify New Force Married (Specify New Force Married (Specify New Force Married (Specify New Force Married (Specify) 10. Ne	10d. Inside City L.									
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20b. Place of Disposition 1\times 2 Creation 2 Character 2 Cha	20905									
SOL LEVINSON & BRO 8900 REISTERSTOWN ROAD PIKESVILLE 23e. Part bitter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in deeth) Due to (or es e consequence of): Due to (or es e consequence of): Due to (or es e consequence of): Due to (or es a consequence of): Due to (or es a consequence of): Due to (or es a consequence of): 1	ty or Town, State LE MD									
Due to (or es e consequence of): Sequentially list conditions if any, leading to immediate Ceuse (Disease or injury that initieted events resulting in deeth) Last Due to (or es e consequence of):										
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Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24e. Wes an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes No 26. Place of Death (Check only one) 27. Magner of Deeth Nursing Home 5 Residence 6 Other 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury 28e. Date of Injury 28d. Describe how injury occur 28e. Place of Injury - At home, farm, street, fectory, office 28f. Location (Street and Number of Check only one) 29a. Certifier (Check only one) 28d. Describe how injury occur 29d. Certifier (Check only one) 28d. Describe how injury occur 29d. Certifier (Check only one) 28d. Describe how injury occur 29d. Certifier (Check only one) 28d. Describe how injury occur 29d. Certifier (Check only one) 28d. Describe how injury occur 29d. Certifier (Check only one) 28d. Describe how injury occur 29d. Certifier (Check only one) 28d. Describe how injury occur 29d. Certifier (Check only one) 28d. Describe how injury occur 29d. Certifier (Check only one) 28d. Describe how injury occur 29d. Certifier (Check only one) 28d. Describe how injury occur 29d. Certifier (Check only one) 28d. Describe how injury occur 29d. Certifier (Check only one) 28d. Describe how injury occur 29d. Certifier (Check only one) 28d. Describe how injury occur 29d. Certifier (Check only one) 28d. Describe how injury occur 29d. Describe how injury occu	C.									
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. Great memorial district.										
TO MAKE A STATE OF THE STATE OF	(Month, Day, Year)									
30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)										
31. Dete filed (Month, Day, Year) 100032. Registrer's Signatures (Month, Day, Year)										

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State of Maryland / Department of Health and Mental Hygiene

					ar y roar r		ificate of		R	eg. No.	9	1521	3.7		
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4	/Medi		STEPHEN C. KASPE						FEBRUAR!		999	8:50	A.M.		
ы	Examir	ıer	4a. Fecility Name (If not institution, give 3508 BRENDAN AVEN		4b. City, Town, or Location of Death 4c. County of Death										
Н	Funeral	-	5. Social Security Number 6. Se		e (In vrs. I	ast birthday)	If Under 1 Yea		TIMORE 's. 8. Date of Birth		I/A	plece (State	or Foreign		
	Funeral Director			ÓM 2□F 91		Yrs.	Months Days			1907	ARYLAI	VD			
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	e Ma Sa-f a	ctor	MARYLAND N	I/A		BAL	TIMORE					1 X Ye	s 2 No		
	or 2	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of	Whet Cou	intry?			
21215-0020 d within 72 hours after death with the Maryland	e 23e	eral	3508 BRENDAN AVENU			2 42 14		21213		u. s					
	n 72 hours after death with the Marylan "natural", or items 23e or 28e-f ahow sideal Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1					14. Race - American Indian, Black, White, etc. Specify: WHITE						
2-0	hin 72 ho a. An *natur Medical	eted	15. Decedent's Edu (Specify only highest grad	location		16a. Deceder	nt's Usual Occu	upation e during most of wo	orkina	16b. Kind of Business/Industry					
121		Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)					GLEN L. MARTIN/ MARTIN MARIETTA					
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	C = 8 L		MRS. EMILY KASPER						BALTIMORE	•			3		
ore,	t a pet		20a. Method of Disposition		20b. PI	ace of Disposit	ion (Name of	acel		20c. Location					
imo	Pages nent of I int: If ite		1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	2/22/99 B	BAITIMO	RF. I	MARVIA	LMD _							
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME INC. 3331 BREHMS LANE, BALTIMORE, MARYLAND 21213												
п			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused	the death	. Do not enter	the mode of dy	ing, such as cardia	BALI IMUK ac or respiratory arm	est, MAK	y LANI	Approximation of the control of the	ate		
//	Physician /Medical Examiner	ler	Immediate Cause (Final disease or condition resulting in death) a. Chronic obstructive pulmonary disease 10 in the consequence of the consequence												
6	and al-transit	Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury	b.—	Oue to (or	as a conseque	nce of):				- 1				
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33		Con							1 □ Y€	s 2 No	1	□ Yes 🍳	No		
/ita	ysician: The sectificate director, pag	Be	25. Wes case referred to medical examiner?						eath (Check only on	е)					
on of Vital	ding Phys h. After this funeral di	tlon: To	27. Menner of Death 101 Natural 2 Accident 5 Pending investigation	lospital: 1 ☐ Inpatier 28a. Date of Injun (Month, Day	v	R/Outpatient 28b. Time of Injury	28c. Inju		Home Reside			(fy)			
Division	P # 5 =	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc.			t, factory, office				a <i>l Route N</i> u	mber.			
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edicai (29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of ner: On the basis of and manner stat	examinati	rledge, death or on and/or inves	ccurred et the t	ime, date and plac opinion, death occ	ce, end due to the ce curred at the time, da	euse(s) end ma ate end plece,	enner as a	steted. to the ceuse	(s)		
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			30. Name and address of person who co	A VAI	JIK	23a) (Type, Pri	D, 3	3400 }	Brehms,	hane	Balt	imore	MD		
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** HAROLD L KAUFFMAN FEB. 20 1999 0410 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Manor Care - Rossville Rossville **Baltimore** If Under 1 Year 6. Sex 1XXM 2□ F 8. Date of Birth (Month, Day, Year) May 1 1912 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Vrs 192-01-4026 86 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Md. Baltimore 1 ☐ Yas 2 ☐ No Director Rosedale 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 8545 Pulaski Highway 21237 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, atc. 1 Never Merried 2000 Never Merried TX Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Ward & Turner Co. 6th Machine Operator permit. Pages 1 and 2 should be file Department of Health and Mental Hyg important; if flem 27 is marked other any injury or other traumented other pages. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Kauffman Elizabeth 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mildred Kauffman / wife 8545 Pulaski Highway Baltimore Md. 21237 20b. Place of Disposition (Nama of cometery, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stete 1 XBurial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Cemetery 2/23/99 Baltimore Md. 21. Signature of Funeral Service Licer 22. Name and Address of Facility Connelly Funeral HOme of Essex 300 Mace Ave. Baltimore Md. 21221 one cause on aach line. Lerry 23a. Part1. Enter the disease, or companies shock, or heart failure. List arrive Approximata Interval Batween Onset and Death **Physician** Immediate Causa (Final disease or condition rasulting in death) Cardiac /Medical Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medicai Due to (or es e consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Acure renor Loulane 1 Yes 2 No 3 Probably 4 Onknown Type II DM. Records. þ 24b. Wara autopsy findings available prior to completion of causa of death? Completed 24a. Wes an autopsy 1 Yes 2 No 1 Yes 2 No Division of Vitai 25. Was casa refarred to medicat axaminer? 8 26. Piace of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) edical Certification: To this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? After or Attanding 1 Natural 5 Pending investigation death. 1 Yes 2 No 2 ☐ Accident after death 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stata) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) À 4 Homicide To the Hospital o within 24 hours at To the Funeral D completely filled I Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Yea D - 38-754, 02-22-99 29b. Signature end title of certifier 29d. Date signed (Month, Day, Year)

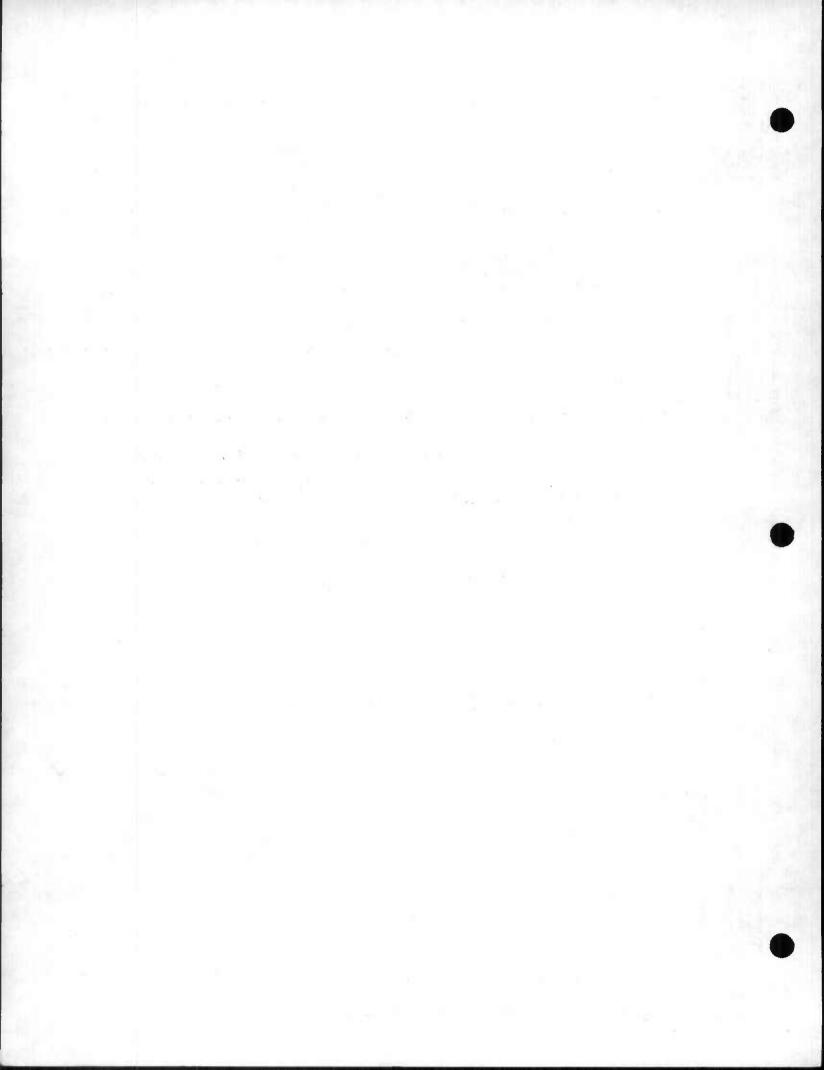
State Registrar

31. Date filed (Month, Day, Year) FEB 2 3 1999

- MD

30. Name and address of person who completed cause of death (Rem 23a) (Type, Print)

A A LICA LIAS BEM. 40 H. BASTERN BLVD, MD - 2 (22) 32. Registrar's Signatu



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year February 13, 1999 **Physician** Rose Catherine Koppleman 12:35 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 218 D. Street, S.W. Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sept. 1, Birthplaca (State or Foreign Country) **Funeral** Days 216-03-3197 1□ M 2□ F 1, 1918 Maryland Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Glen Burnie 1 Yes 2 No Director 28e-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? rms 23a or 218 D. Street, S.W. 21061 U.S.A. Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Reca - American Indian, Bleck, White, etc. filed within 72 hours after 1 Never Merried 2 Married 1 Yes 2 No If Yes, Give Year or Dates: b 21215-0020 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 12 Own Home Homemaker Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fis. Department of Health and Mental Hy Important: If them 27 is marked oth any injury or other traumatic event Be Catherine Ann Hopkins William August Herrlich 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael E. Koppleman/son 218 D. Street, S.W., Glen Burnie, Maryland 21061 20b. Placa of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 5 ☐ Other (Specify) 4 Donation 21. Signature of Funeral Service License Ronald S 22. Name and Address of Fecility
State Anatomy Board, 655 W. Baltimore Street Wade, Director Dill Baltimore, Maryland 21201 23a. Part Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Fine! ARTERIOSCIENOTIE CARDIOVASCULAR 5 YEARLO disease or condition resulting in death) Examiner DISGASA Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical use as the Dua to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown STROKE ate has been signed pege 2 should be de P 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Wes an autopsy EMPHYSEMA 1 Yes 2 No 1 ☐ Yas 2 ☐ No certificate Division of Vitai After this certifical funeral director, p or Attending Physicien: 25. Was case referred to medical examiner? 8 26. Place of Death (Check only gne) Hospitel: 1 Inpatient 2 ER/Outpalienl 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Aesidence 6 ☐ Other (Specify) edical Certification: To 1 Yas 2 No 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? in 24 hours after death.
The Funeral Director: After Malain filled in by the fu 5 Pending 1 Natural 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, term, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completaly fi (Check only one) 29b. Signature and Title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 1929 Nuo 21776 FBRUARY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year) FEB 2 2 1999

MUNURA 32 Registrar's Signature

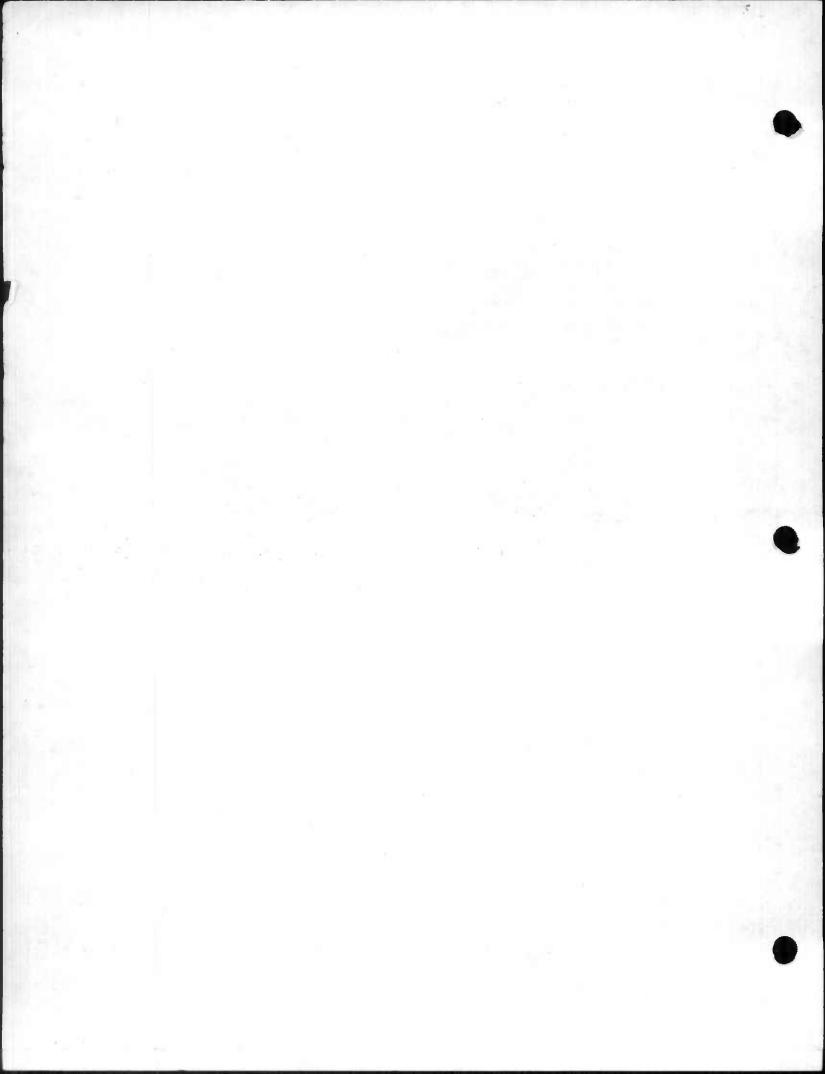
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. Pages 1 and 2 should be fill trent of Health and Mentel H tant: If Item 27 is marked oth jury or other traumatic even

Physician /Medical Examiner

Important: If it any injury or c

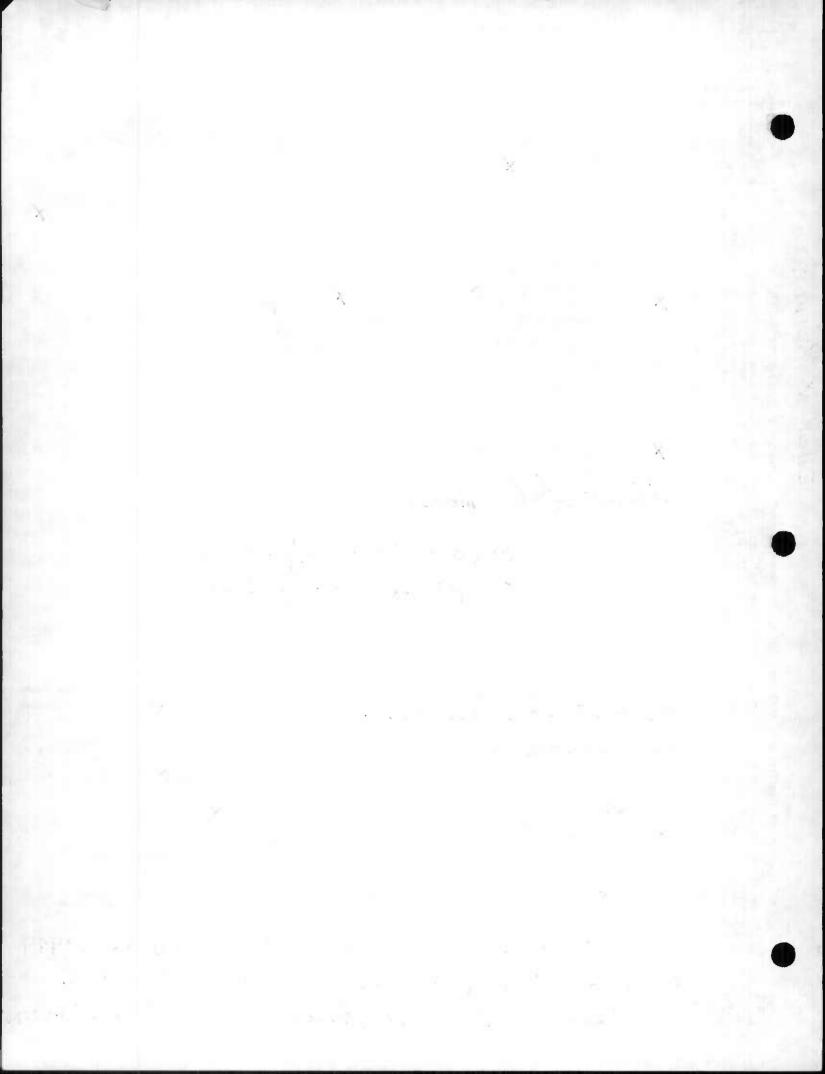
physician end the burief-transit death certificate be executed P.O. Box 68760. as esn Division of Vital Records. Attending Physician: funerai s efter death. 1 24 hours efter dea to Funeral Director pletely filled in by th 6 within 24 hor To the Fune completely fi

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth Ellen Virginia Kerwin 4:57 PM February 21, 1999 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Ellicott City 8809 Old Frederick Road If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 5 Sociel Security Number 7. Aga (In yrs. lest birthday) Birthplece (Stete or Foreign
Country) 1□M 2 F Months Days 93 Yrs 216-36-4235 July 5, 1905 Virginia Usual Residence of Decedent 10a. State 10h. Counts 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21043 U.S.A 8809 Old Frederick Road Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien Bleck, White, atc. 1 ☐ Never Married 2 ☐ Merried 1 Yes 2 No If Yes, Giva Yeer or Detes: 1 ☐ Yes 2 No Specify. Specify. White þ 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16h Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Home Homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Ellen Catherine Vickers **Edward Verts** 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 6737 Pine Drive Columbia, Maryland 21046 Ms. Ellen Gosnell Daughter 20b. Place of Disposition (Neme of cematery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burlal 2 □ Cramation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 02/24/99 Ellicott City, Maryland Good Shepherd Cemetery 21. Sjurill ure of Funeral Service Licentu 22. Name and Address of Fecility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 M00535 234 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line. Approximate Intervel Between Onset end Deeth Immediate Cause (Final disease or condition resulting in deeth) ocardia Physician/Medical Examine Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Dua to (or es e consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were eutopsy findings evailable prior to completion of causa of deeth? 24e. Wes en eutopsy performed? Completed 25. Was case referred to medicel exeminer? Be 26. Plece of Deeth (Check only one) To 1□ Yes 2X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Date of Injury (Month, Day Year) 27. Menner of Death 1 Naturel 2 △ Accident 28d. Describe how injury occurred 28h. Time of 28c. Injury et Work? Certification: 5 ☐ Pending 1 Yas 2 No invastigation 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end manner statad. 29a. Certifier edical (Check only one) 29b. Signature and title of certifier 29d. Date signad (Month, Day, Year) 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 201 laurel Pork Nicholo ATGRATE 31. Date filed (Month, Day, Year) 32. Regist FEB 23 My 2074

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death LEWIS -LBE 30 am 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL FAMARITAN BALTIMORE If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) Months Hours M 2□ F 230-12-4001 79 07-19-19 VA Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits NA YYes 2 No Baltimore 10e. Street and Number 10f, Zip Code 10a. Citizen of Whet Country? 614 Radnor Avenue 21212 USA 12. Was Decedent Ever In U,S. Armed Forces? 14. Rece - American Indian, Black, White, etc. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) XIX Yes 2 ☐ No if Yes, Give Year or Dates: 1□ Yes 2 No Specify: Black 3 Widowed 4 Divorcad 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratirad) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12th Grade Postal worker U.S. Post Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Albert Lewis, Sr. Unknown 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 21213 19a. Informant's Name/Relationship (Type, Print) 614 Radnor Avenue Baltimore, Maryland Augusta Lewis 20b. Placa of Disposition (Name of cametery, cremetory or other placa) 20c. Location - City or Town, State MD 20e. Method of Disposition 1X Burlal 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest VA Cem. 02-24-99 Owings Mills, 21. Signature of Funeral Servica Licans 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate MYOCARDIAL INFARCTION Immediate Ceuse (Finel disease or condition resulting in deeth) 30 MINS. Due to (or es a consequence of) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting In death) Last Due to (or as a consequence of) Due to (or as e consequenca of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were eutopsy findings available prior to completion of cause of deeth? 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Placa of Death (Check only one) Hospital: 1 npatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Yeer) 27. Menner of Deeth 28d. Describe how Injury occurred 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide

ician and buriel-transit physician s the buriel Division of Vital Records, P.O. Box 68760. 950 Deen funeral After t

Physician

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Physician/Medical þ Completed Be 2 Certification:

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Physician

/Medical

Examiner

MD

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permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Manylan Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itema 23a or 28a-f show any Injury or other traumatic event, the Modical Examined round by notified at

Baltimore, Maryland 21215-0020

 Hospital or Attanding P
 24 hours efter death.
 Funeral Director: After t To the Hospital of within 24 hours e To the Funeral D

29b. Signature end title of certifie

29a. Certifier

(Check only one)

29c, License number

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, dete end piece, and due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, dete and place, end due to the cause(s) and manner stated.

29d. Date signed (Month, Dey, Yeer)

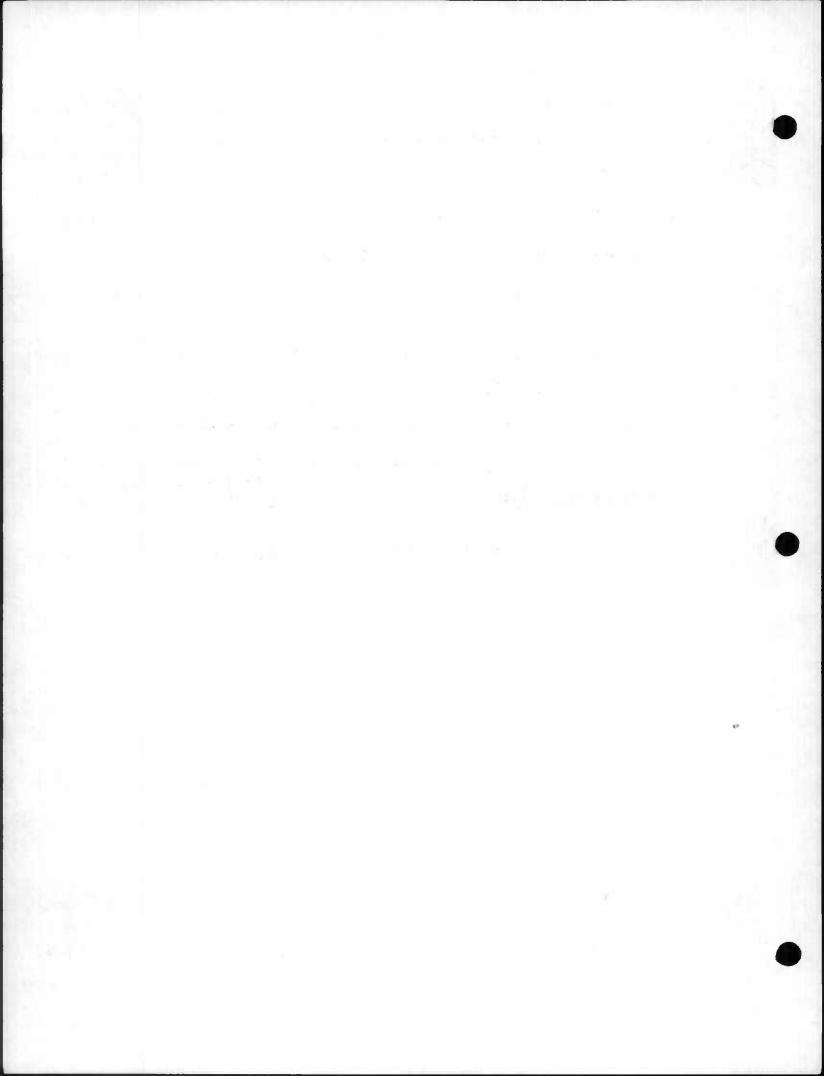
21239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WALIS ABOUTAOUDE 6926 DONASHIE

1999 32. Registrar's Signature

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth Month **Physician** 1999 2:15 P.M. Lee Agnes May 22 TEBRUARY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Rosedale

It Under 24 Hrs. 8. Dete of Birth
(Month, Day, Year)

Tune 29, 1907 Examiner SQUARE HOSPILA 11 MORE If Under 1 Year 6 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1□M 2XF Days 91 Yrs. Virginia 219-20-8263 Director Usuel Residence of Decedent with the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-1 show other treumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland Baltimore Baltimore Directo 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 2223 Redthorn Road 21220 U.S.A. Pages 1 and 2 should be filed within 72 hours effer death in ant of Health and Mentel Hygiene.
Int. If Item 27 Is marked other than "natural", or Items 23. Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1X Never Married 2☐ Married 1 Yes 2 No Specify: altimore, Maryland 21215-0020 Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) House Keeper Family Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) Be Alice Inscoe Vivian Fitzhugh M. 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 4 Opie Road, White Marsh, Maryland 21162 Ester Elizabeth Busch (niece) 9 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Burial 200 cremetion 3 ☐ Removal from State 2/23/99 Baltimore, Maryland Green Mount Crematory 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Lices 22. Name and Address of Fecility Bruzdzinski Funeral Home, P. A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finat diseese or condition resulting In death) a. Respiratory Insufficiency
Due to (or es a/consequence of): 15 HOURS Examiner Examiner physicien end the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in death) Lest Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): for use es t Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco usa contribute to the cause of death? been signed by the s should be detached 1 Yes 2 No 3 Probably 4 Unknown , AnxieTy Dementia 24b. Were eutopsy findings available prior to completion of ceuse of deeth? Completed 24a. Wes en eutopsy performed' s certificete has b director, page 2 s 1□ Yes 1 TYes 2 No or Attending Physician: funeral director, 25. Wes cese referred to medical Be 26. Plece of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending after deeth. 1 Yes 2 No investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 2 4 Homlcide 24 hours Furieral Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner as steted.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) and manner stated. Medical 29a. Certifier (Check only one) To the 1 within 2 To the 9 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer)

WD

32. Registrer's Signeture

man of person who completed cause of deeth (Item 23e) (Type, Print)

00053617

9000 FRANKlin Square DR. BATTIMORE, MARYLAND 21237

State

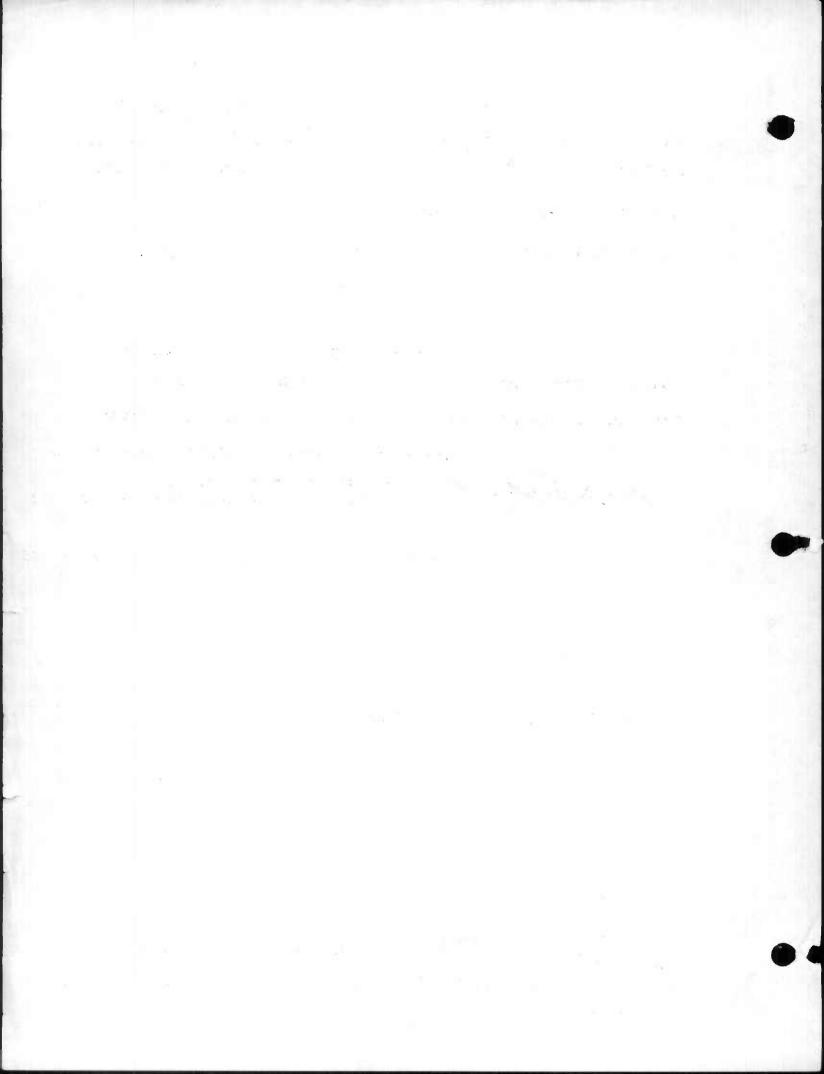
Registrar

DHMH 16 Rav 6/95

30. Name and addr

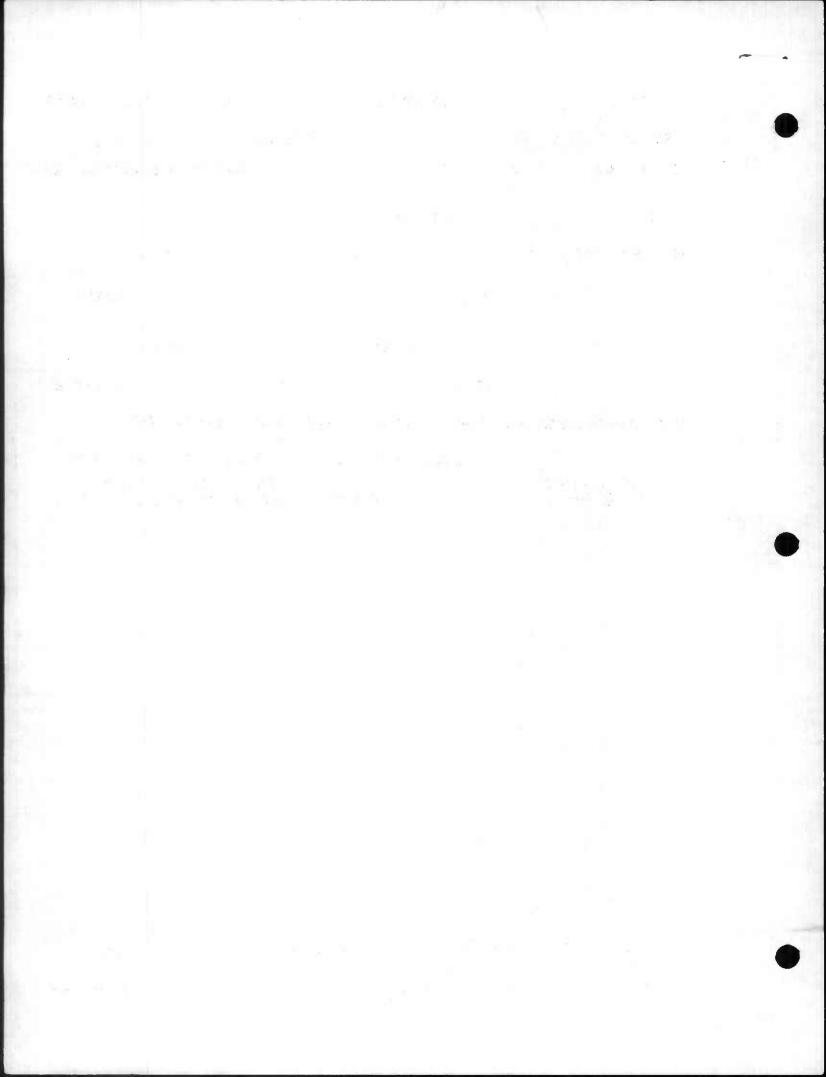
JR HASSA VASS ER

FEB 23 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

		Certificate of Death Reg. No.											293		
Physici: /Medic		1. Decedant's Name (First, Middla, Last) GERTRUDE LEFKOVITZ									P5 1999		3. Time of Death 8:30AM		
Examin		4a. Fecility Neme (If not institution, 2910 TERRY DRIV	LEFKOVITZ 2. Date of Death FMSh Pg 1959 8:308 8:308 8:308 Pg 1959 8:308 8:308 Pg 1959 Pg 1959 8:308 Pg 1959 P												
Funeral Director		5. Social Security Number 276–18–5289			2					8. Deta of Birth	9 ⁷ 1915	9. Birthple JERUS!	ace (Stata or Foraign LEM ISRAE		
M 11		Usual Rasidance of Decedent 10e. State 10b. County	- /	10c. C	City, Town or L	ocation						100	d. Insida City Limits		
Maria sh	ctor	. 1/4											1X Yas 2 □ No		
tal Hygiena. d other than "natural", or hems 23a or 28a-f show event, the Madical Examiner must be notified at	i Dire	10e. Street and Number 2910 TERRY DRIVE	APT.	D											
*natural", or items 23a or 28a-f show solcal Examinal must be notified at	by Funeral Director	11. Maritel Status 1 □ Nevar Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorcad	Armed F d 1 ☐ Yes If Yas, G	orces? 2X No Siva	U,S. 13.				gin? (Spe , Puerto i	cify Yes or No- Rican, atc.)	14. Rac Bie	ce - America ck, Whita, at	tc.		
Comp		15. Decedant's (Specify only highast Elemantery/Secondapy 20-12)	grade completed	College (1 Ass 5:)			al Occup ork dona se retired	oation during most d)	of worki	ng					
c even		17. Father's Nama (First, Middla, Li HERMAN	est)	SENDER	S					(First, Middla,	Maidan Sumame) WERTHEIMER				
7 is trait		19a. Informant's Name/Ralationshi RABRT MORRTS LEE	HUSBAND		_							Code)			
Important: If item 2 any injury or other once.		20a. Mathod of Disposition	MRemoval from	20b.	Placa of Disp comatary, cra	osition (Na matory or o	ma of other piec			Date	20c. Location	City or Tow			
any inju		21. Signature of Juveral Service L	90										īC.		
buysiolen end miner the burial-transit the burial-transit	edical Examiner	Immediata Cause (Final disaasa or condition rasulting In daath) Sequantially list conditions, if any, laading to immadiata cause. Enter Undarfying Cause (Disease or Injury that initiated events rasulting in deeth) Lest	e	Dua to	(or es e conse	quanca of):									
> 6	Physician/Me	Part II. Other significant condition	d	death but not re	sulting in tha u	undariying d	ausa giv	ren in Part i.		23b. Did to	obacco use co	ntribute to t	the cause of death?		
should be detached for use	þ	Parlinson's Disease								\/			ably 4□Unknown		
e 2 should	Completed									24a. Was i	med?	avail	a autopsy findings lable prior to pletion of causa aath?		
tor, pag	Be Co	25. Was case rafarred to medical						26 Place	of Deeth	1 TY		10	Yas 2□ No		
direc	ToB	axaminer? 1 ☐ Yas 2 No	Hospital: 1	Inpatiant 2	ER/Outpatie	nt 3 D0	OA Oth	05:		ne 5 Resid		ar (Specify)			
To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	27. Mannar of Death 1 Death 2 Accident 3 Suicida 4 Homloide	tion t be 28a. Plea	nth, Day Year)	28b. Time of Injury	ime of plury at Work? M 28c. Injury at Work? 1 Yas 2 No The streat factory office 28f. Locat					d. Describe how Injury occurred f. Location (Streat and Number or Rural Routa Number, City or Town, State)				
Funeral Di stely filled Ir	edical Cer	29a. Certifier 12 Certifying	Physician: To the	a best of my kn	owledga, daat	h occurred	at the tin	na, data and pinion, daet	d place, a	and dua to tha c	ausa(s) and m	annar es sta and dua to t	ted. ha causa(s)		
To the comple	Med	29b. Signeture and title of certifiar	er i					a number	061		2 / 1 S				
	te	30. Nama and address of parson when the second of the seco	NOAT.S	Isa of daath (Ite Side Registrar's Sign	em 23a) (Type,	Print)	1,20	401 1	J. B	Selvedo	me Ave	, But	finance		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Day Month LITTLE MARGARET 310 AM FEBRUARY 16 1909 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Severna Park Anne Arundel Co. Genesis Eldercare 8. Date of Birth (Month, Dey, Year) April 5,1916 If Undar 1 Year if Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign Days Hours 1□M 2⊠F 82 Yrs Maryland 220-09-0348 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 U.S.A. 7900 Benesch Circle Apt. 797 12. Was Decedent Ever in U,S. Armad Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - Amarican Indian, Biack, White, etc. 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: 1 Naver Marriad 2 Married White 1 ☐ Yas 2 ☑ No Specify: 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working iife. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 N/A Homemaker Own Home 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Unknown Bennett Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 508 chester River Beach Road Grasonville, Md. 21638 Marguerite L. Moore 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ₺ Buriai 2 □ Cremation 3 □ Removal from State Glen Haven Mem. Park Feb. 20, 1999 Glen Burnie, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Sarvice Licensae 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part1. Enter the diseasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Immadate Cause (Final disease or condition resulting In death) CONGESTIVE HEART FAILURE Week Due to (or as a consequence of): CARDIOVASCULAR ARTERIOSCUSTOTIC Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Ohknown DEMENTIA ATRIAL FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

Physician /Medical **Examiner**

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signed by the ettendin be deteched for use

page 2

filled in by

si or Attending Physician: T s efter death. ii Director: After this certifical funerel director,

24 hours Hospital

To the within 2

The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records.

Depertment of important: If any injury or

Physician

/Medical

Examiner

Funeral

Director

rai', or items 23a or 28a-f show Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours efter death anent of Heelih and Mentel Hygiene.
The state of th

Baltimore, Maryland 21215-0020

Director

Funeral

Completed by

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Certification: To

Medical

Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last

1 Yes 2 Ano 26. Place of Death (Check only one)

1 Yes 2 No

25. Wes cese referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Menney of Deeth 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Netural

Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

21776 FABRUARY 18 1999

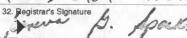
29d. Data signed (Month, Day, Year)

30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print)

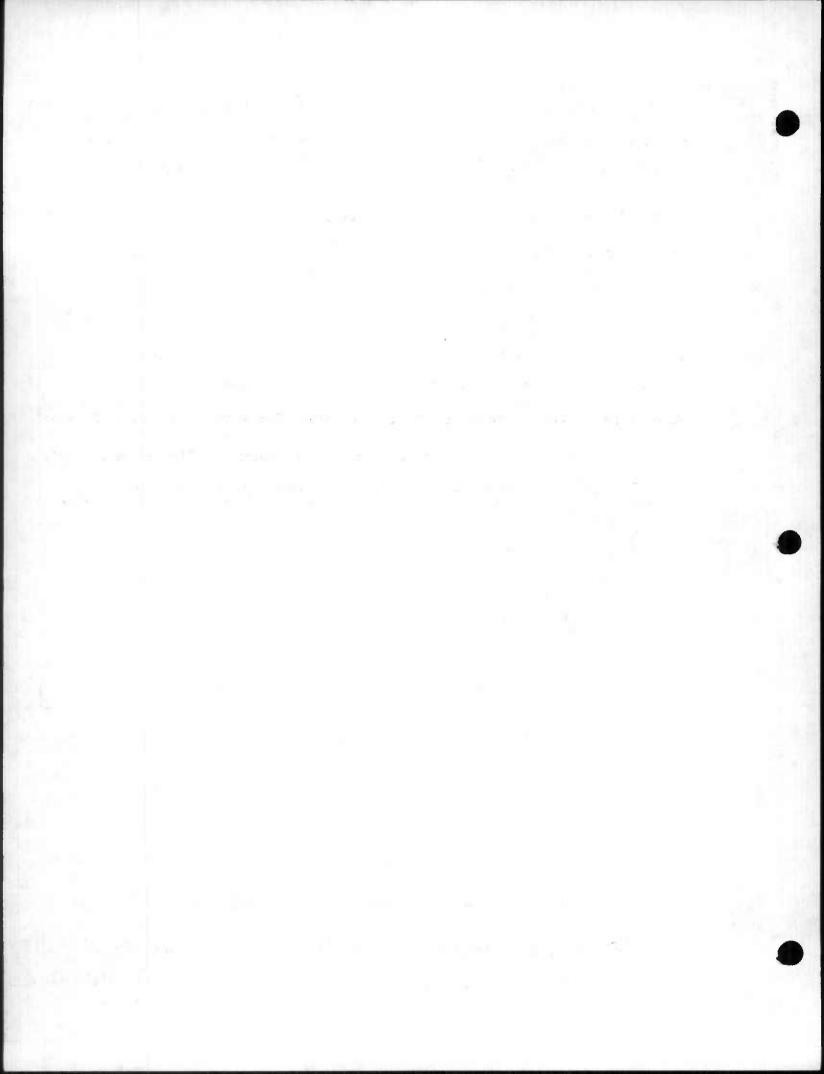
MO 8/09 RITCHIE HWY PARADENA MO 2/122 FURNIA MUNDRA 31. Data filed (Month, Dey, Year)

State Registrar

FEB



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dele of Death 3. Time of Death Month Dev Year EUGENE ERWIN LONG FEBRUARY 19, 1999 8:40PM 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Saint Joseph Medical Center Baltimore Towson If Under 24 Hrs. If Under 1 Year 5. Sociel Security Number 7. Age (In vrs. lest birthdev) Birthplece (State or Foreign Country) 6. Sex 8. Dale of Birth (Month, Dey, Yeer) Min. 100 M 2□ F Months Deys Hours Apr. 20,1910 212-03-2908 Missouri Usuel Residence of Decedent 10e. Stete 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No No Maryland Baltimore County Anneslie 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21212 USA 615 Anneslie Road Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Maritel Stetus 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 X Yes 2 No 1 ☐ Never Merried 2 ☑ Merried Specify: White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Detes: WW2 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Paper Box and Elementery/Secondary (0-12) College (1-4or 5+) Steel Rule Die Maker Container Production 12th 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Ollie Beasley Herman Frederick 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 615 Anneslie Road, Baltimore, Maryland 21212 Nina Evelyn Long (Wife) 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremelion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 2/22/99 Baltimore, Maryland Green Mount Crematory 21. Signature of Funeral Service (Tidense) 22. Name end Address of Fecility Mitchell-Wiedefeld Home, Inc. PIARTIN D. Lawson 6500 York Road, Baltimore, Maryland 21212 23a. Pertl. Enter the disease, or complications thel caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximately 100 and 100 an Approximete Intervel Between Onset end Deeth Immediate Cause (Finel disease or condition resulting in deeth) CONGESTIVE HEART FAILURE Due to (or es e consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events Due to (or as a consequence of) Due to (or as e consequence of) resulting in death) Lesl Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown MULTIPLE CEREBRAL THROMBSIS 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28b. Time of Injury 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending investigation

Physician /Medical Examiner

Examiner

Physician/Medical

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permit. Pages 1 and 2 st Depertment of Health and Important: If Item 27 Is in any injury or other traun DINCE.

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f ehow

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Funeral

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Completed

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death

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d be filed within 72 hours and Hygiene.

The law requires that the death certificate be-executed attending p for use es 8 ed by the a

Division of Vital Records, P.O. Box 68760 is certificate has bil director, pege 2 s Physician: this funeral After t or Attending death. Director: d in by the A 24 hour. the Funeral Directory

completely within 2

> State Registrar

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner stated. 29b. Signeture end title of certifier millia m.o

29c. License number

1 Yes 2 No

29d. Date signed (Month, Day, Year) Q

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Name end address (* Person who completed cause of deeth (Item 23e) (Type, Print)

JOGINDER P. M. D. . 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 MEHTA,

31. Dete filed (Month, Dey, Year)

2 Accident

3 Suicide

29a. Certifier

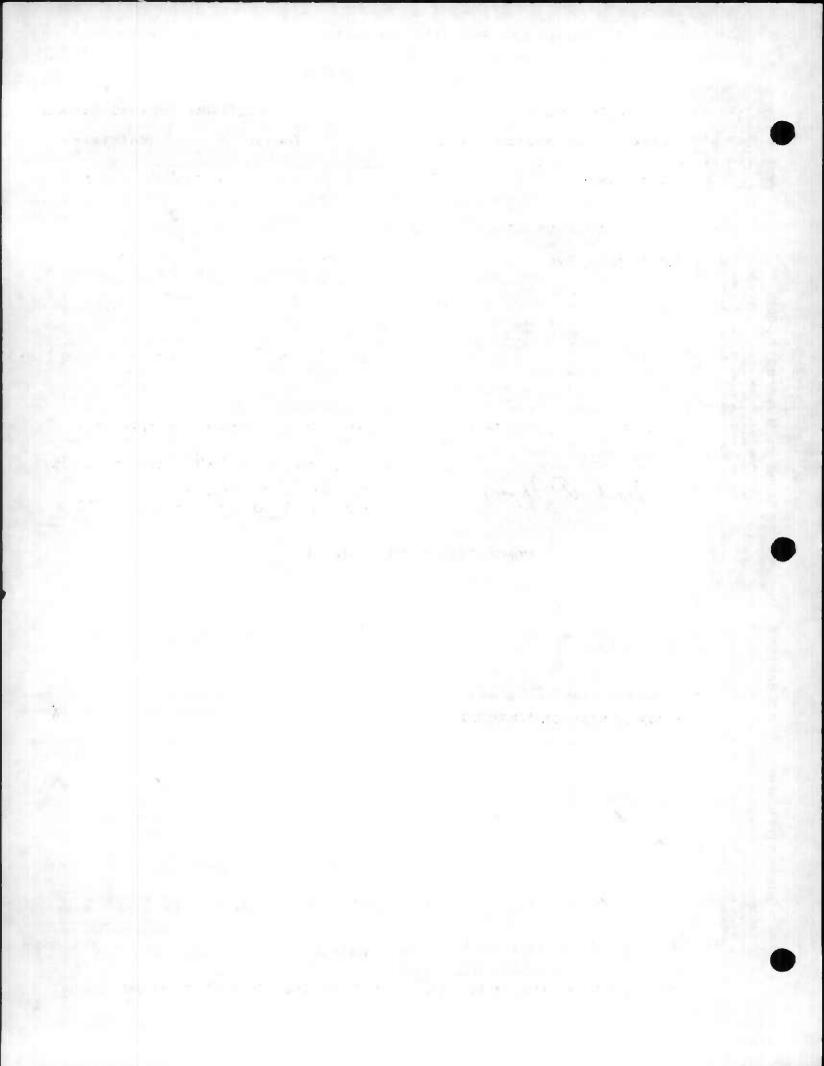
4 Homlcide

(Check only one)

6 Could not be determined

32. Registrer's Signeture

28e. Plece of Injury - Al home, ferm, street, fectory, office building, etc. (Specify)



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 1. Decedent's Name (First, Middle, Last) FC6 reary Jean Larter 320 am 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Baltimore City Ba Hopkins Bayview Hospital Baltimore City 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 X F Yrs October 15,1913 Steelton, PA 204-03-9448 Usual Rasidenca of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Baltimore Maryland Kingsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21087 13 Wesley Woods Court U.S.A. 14. Raca - Amarican Indian, Black, Whita, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Yaar or Dates: 1 Naver Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Midowed 4 □ Divorcad White 15. Decedent's Education (Specify only highest grede complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Social Security Elamantary/Secondary (0-12) Collage (1-4or 5+) Administration 12 yrs. Vrs. Case Worker 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) John Hancock Kirkpatrick Mary Shockey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 13 Wesley Woods Court Kingsville, Maryland 21087 ace of Disposition (Name of Data 20c. Location - City or Town, State Mr.Kirk E.Larter_(Son) 20b. Place of Disposition (Name of cemetery, cremetory or other pleca) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Cemetery 2/20/99 Towson, Maryland 21204 22. Name and Address of Facility 21. Signature of Funeral Service Lice E.F.Lassahn Funeral Home 11750 Belair Road Kingsville, Maryland 21087 Approximate refer the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter shock, or haart failure. List only one cause on each line. Congestive Keart Failure 1 week Immediate Cause (Final disease or condition rasulting in daath) Due to (or as a consequenca of): / week Aspiration prelimenta Dua to (or as a consequenca of) Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown dementia 24b. Ware autopsy tindings available prior to completion of causa of daath? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case ratarred to medical 26. Placa of Death (Check only one)

Physician /Medical Examiner

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To

Certification:

Medical

State

Registrar

certificate be execu

P.O. Box 68760.

Division of Vital Records.

Physician

· /Medical

Examiner

10a. State

Director

Funeral

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Completed

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at

permit. Peges 1 and 2 should be filed within 7. Department of Heelth and Mentel Hygiene. Important: If Item 27 is marked other than "ns any injury or other traumatic event, the Media pace.

with the Marylend

Baltimore, Maryland 21215-0020

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical þ Completed

Alzheimer

Hospital: 1 Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Mannar of Death 1 Watural 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding investigation 1 ☐ Yas 2 ☐ No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicida 6 Could not be 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29a. Certifier

29c. Licansa number

29d. Data signed (Month, Dev. Year) February 18, 1995

30. Name and address of person who complated causa of death (Item 23a) (Type, Print)

Sandy Chendra . 4940 Eastern Avenue

Shede. MD

Balt more

31. Date filed (Month, Day, Yeer)

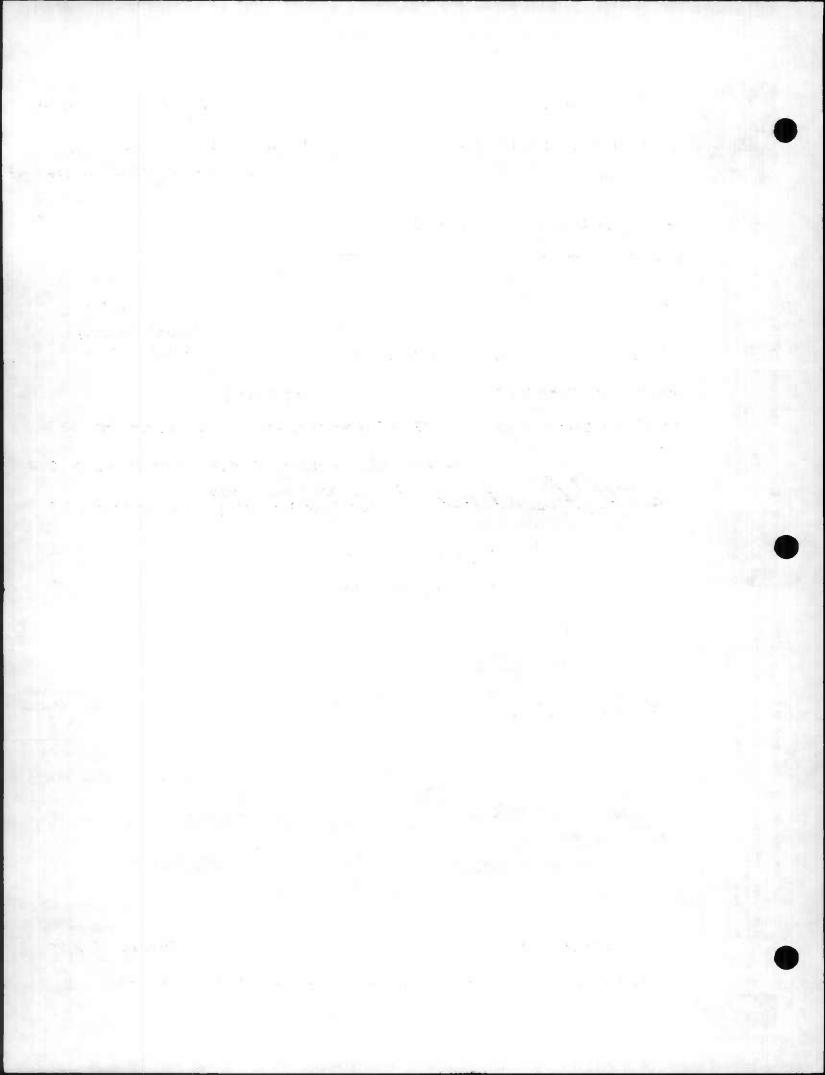
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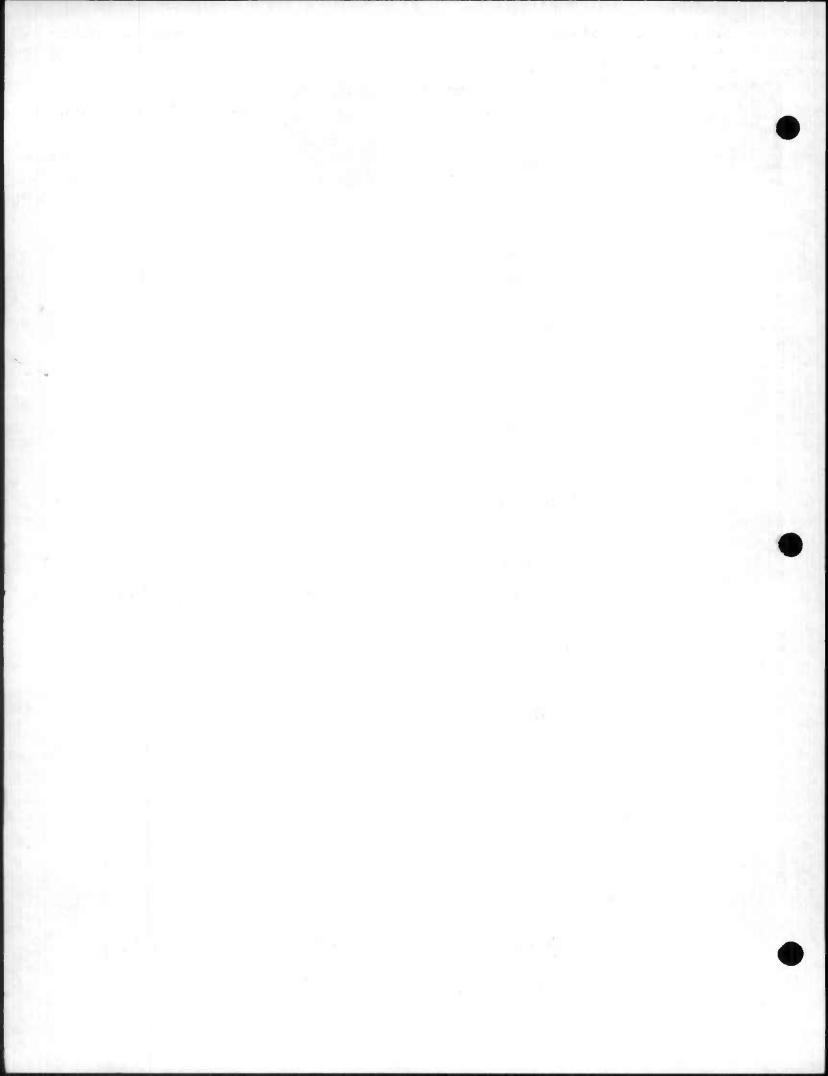
To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director;



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Attending Physician: or death. ector: After this certific by the funeral director,	atio	1 Naturei 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Dey	Year)	njury M		rk? Yes 2 ☐ No					
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Nexie Month **Physician** atthews :30 A. M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva streat and number) D. City, 1...

Dalfmore

If Undar 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year)

8-21-1923 Examiner Cathedral reet Apt K12

7. Age (In yrs. last birthday) | Il Under 1 Year street 5. Social Security Number 6. Sex 1 M 2 □ F Birthplaca (State or Foreign Country) **Funeral** Months Days 241-24-0375 Director Usual Residence of Decedant with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Haelth end Mentel Hygiene. Important: if item 27 is merked other than "natural", or items 23s or 28s-f show any highry or other treumatic event, the Medical Examination must be notified an once. 28a-f show 1. No Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21201 U.S.A. Street Apt K Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (D/No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, atc. 1 Never Married 2 Married Black 1□ Yes 2XNo Baltimore, Maryland 21215-0020 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Copanos Elementery/Secondary (0-12) John College (1-4or 5+) happy (oth grade NA 18. Mother's Name (First, Middle, Malden Sumame) 17. Father's Nama (First, Middla, Last) Be hester aglana Mathews OL 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Z/Z 0/ Apt 1athews-wife Cathedral Street 1027 Balto 20b. Placa of Disposition (Name of cemetery, cremetory or other placa) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Ramoval from State 2-24-99 21. Signature of Funeral Service Licenses 22. Name end Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Balto, nd 21215 Approximate Interval Between Onsat and Daath **Physician** /Medical Immediate Causa (Final disease or condition resulting In death) ASCILD Examiner Due to (or as a consequence of): Physician/Medical Examiner attanding physician end for use as the burial-trensit The law requires that the death certificete be axecuted Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Dua to (or as a consequence of): ed by the a detached f 23b. Did tobecco use contribute to the ceuse of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No been signed by t should be detact 3 Probably 4 Unknown by 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? page 2 has 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Homa 5 Rasidence 6 □Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA eral Director: After this filled in by the funeral di 28a. Date of injury (Month, Day Year) 27. Manner of Death

1 Natural

2 ☐ Accident 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No deeth 28f. Location (Straet and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide efter within 24 hours e To the Funeral C completaly filled Certifying Physicien: To the best of my knowledge, death occurred et the time, dete and placa, and due to the cause(s) end manner as stated.

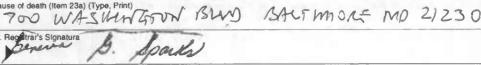
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier edicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. Licansa number

State Registra

BICH DYDWG 31. Date filad (Month, Day, Year) FEB 23

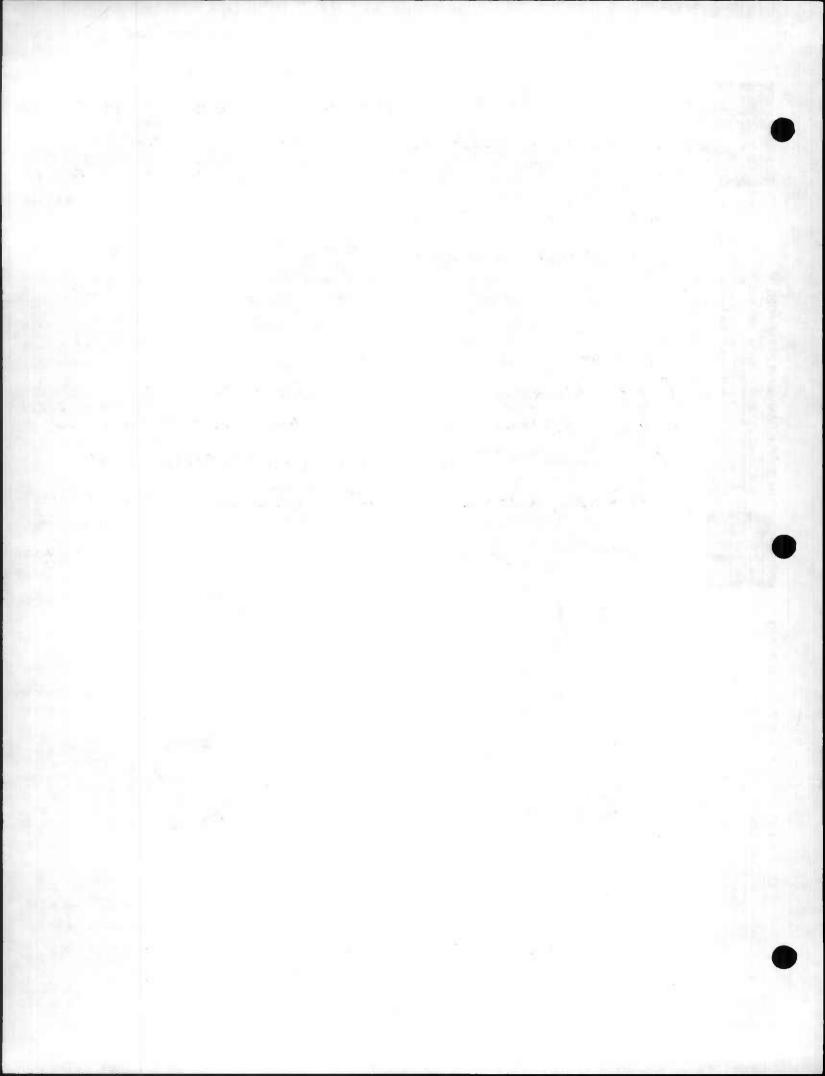
32. Registrar's Signatura

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)



D26256

2/22



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental	Hygiene	0	0	pex	0	0	1
Certificate of Death	Reg. No.		U	5	6	9	

	ASP				State of	f Maryla				Health and N Death	Mental Hy	giene Reg. No.	05	299		
			1. Decedent's Nan	ne (First, Middle, L	ast)	2. Date of De	ath		3. Time of Death							
	Physicia		Patric	ia R. M	lurphy						Month FEBRU	JARY 19	1999	4:49 A		
	/Medica Examina		4a Facility Name (If not Institution, give street and number) 4004 GWYNN OAK AVE BALTI								ocation of Deat	h 4c. County				
ŀ	Funeral		5. Social Security I			7. Age (In y	rs. last birthday		der 1 Year	If Under 24 Hrs.		th	9. Birthple	ice (State or Foreign		
	Funeral Director		213-72-5836 1 M 2 1 A 5 Yrs. Usual Residence of Decedent						ns Days	Hours Min.						
	wo m	-	10a. State	10b. County		10c.	City, Town or L	ocation	17.50	The state of the s			100	d. Inside City Limits		
	Men,	io	MD	NA			Balt	imor	e					X□ Yes 2□ No		
	r 28s	8	10e. Street and Nu	umber			- 43	10f.	Zip Code			10g. Citizen of N	What Countr	y?		
	h wit		4004 G	wynn Oa	k Ave			2	2121	5		U.S	.A.			
	rurs effer deeth with the Meryler et, or items 23s or 28s-f show Examiner must be morified at	Funeral Director	11. Maritel Stetus		12. Was Dece Armed For	edent Ever in	U,S. 13	. Was De	cedent of	Hispenic Origin? (S	pecify Yes or No)- 14. Rac				
0	or the		1 Never Mar	ried 2 Married	1 Tes	2 X No					o riican, etc.)			C.		
00	ours raff,	Ď	3 Widowed	4 Divorced	Year or De			10 10	220110	эреспу.		Specin		ck		
21215-0020	d within 72 hours efter deeth with the Meryland jene. r than "natural", or flems 23a or 28a-f ehow tra Medical Express trust be notified	Completed	(Spe	15. Decedent's E		fe completed) (Give kind of s				during most of wor	king	16b. Kind of B	usiness/Indu	stry		
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Maryland	od a b	ň										, maiden Suman	10/			
Z	2 should be and Ments is marked sumatice.	0	_	Murphy			40h M-1	(2 A -1-1-	(0)				Cara Tin (Darde 1		
Ma	2 0 0 0			lame/Relationship												
	of Health Item 27 other tr	-	Helen 20a. Method of Dis	Murphy-	Mother	201	400	4 Gv	ynn Vame of	Oak Ave						
סר			1 ☐ Burial 2	Cremetion 3			cemetery, cr	ematory o	or other pla	1						
Baltimore,		-		5 Other (Spec							24/99	Glen	Burn:	ie, Md		
Ba	permit. Departnimports any inju		21. Signature of F	uneral Service Lice	ensee			Marc	h F	/H West						
	20240		0.	lady	War	Chan							Md :	21215		
п			23a. Part1. Enter shock, or he	the disease, or cor art failure. List only	nplications that ca y one ceuse on e	aused the d ach line.	eath. Do not e	nter the n	node of dy	ring, such as cardied	or respiretory e	errest,		Interval Between		
	Physician (Martine)			(Etc.)		0 1			-1	1				Jiset and Death		
	/Medical Examiner	1	Immediate Cause disease or conditi- resulting in deeth)	on	a	Kuls	nonar	1	hoo	mbo-En	Molis.	M	- 1			
п		6			3	Due to	o (or as a cond	guence .	=1)	,						
	bet nsit	Examiner			b	Jeej	, Veil			mousir			i			
	sician end buriel-transit	Xa	Sequentially list of if any, leading to it cause. Enter Und Ceuse (Disease of	onditions, mmediate		Dudito	o (or as e conse	equence	of):				i			
8760,			Cause. Enter Und Ceuse (Disease of that initiated event	erlying r Injury	C									Inside City Limits Yes 2 \ No		
687	ifficete ig physes the	Ba	that initiated events resulting in death) Last Due to (or es e consequence of):													
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m	death certificete be executed e ettending physician end of for use as the buriel-transit	Physician/Medical	Part II. Other elec	idland anddlana	anniella sing to ele	ath but not	anding in the	مان بادر مادراد		ives in Boot I	ook Did	tohenno uno no	ntribute to	the series of death'		
0	that the de led by the deteched	J S	raitii. Other signi	A A	contributing to de	sath out not	iesulting in the	undenyii	g cause g	wen in Fatti.						
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Records,											24e. Was	an autopsy	24b. Wer	e autopsy findings		
00	v require	Completed									pert	ormed?	com	pletion of cause		
Re	The law ate hes b	Ē									ud/	Vac DONO				
Vital	certificate rector, pag		25. Was case refe	rred to medical						26 Plans of Day	-			Tes SM MO		
>		a o	exeminer?		Hospital:	npatient 2	□ EP/Outpatie	ont 2	DOA 0	ther _			er (Specify)			
o	g Physer this neral d	- 1	27. Manner of Dea		28a. Date o	of Injury	28b. Time	of			4 40 7					
0	th. : After s funer	0	1 Naturel 2 Accident	5 Pending investigation		h, Day Year) Injury	М								
Division	Attending or deeth. ector: Afte by the fune	1	3 Suicide	6 Could not determine	Zoe. Place	of Injury - A	t home, farm, s	treet, fac	tory, office	•			ber or Rural	Route Number,		
ā	s effe f Dire	Certification:	4 🗌 Homicide		buildir	ng, etc. (Spe	ecity)	Yrs. Monthe Days Hours Min. (Month, Day, Year) Country)								
			29a. Certifier													
	n 24 n 24 ne Fu	edical	(Check only one)	2LXMedical Exa	miner: On the ba end mann	asis of exam ner stated.	ination and/or i	nvestigat	ion, In my	opinion, death occu	rred at the time,	date and piece,	end due to	he cause(s)		
	PEPE !		29b. Signeture and	d title of partitier			70.00		29c Licen	se number		29d Date signe	d (Month D	lav Year)		

To the Hospital or Attending is within 24 hours efter death.
To the Funeral Director: After completely filled in by the funer Division

BEB

31. Date filed (Month, Pay, Pear) 3 199932. Registrate Signature State

1 Certifying Phyalclan: To the best of my knowledge, death occurred at the time, date end pieca, and due to the cause(s) and manner es stated.

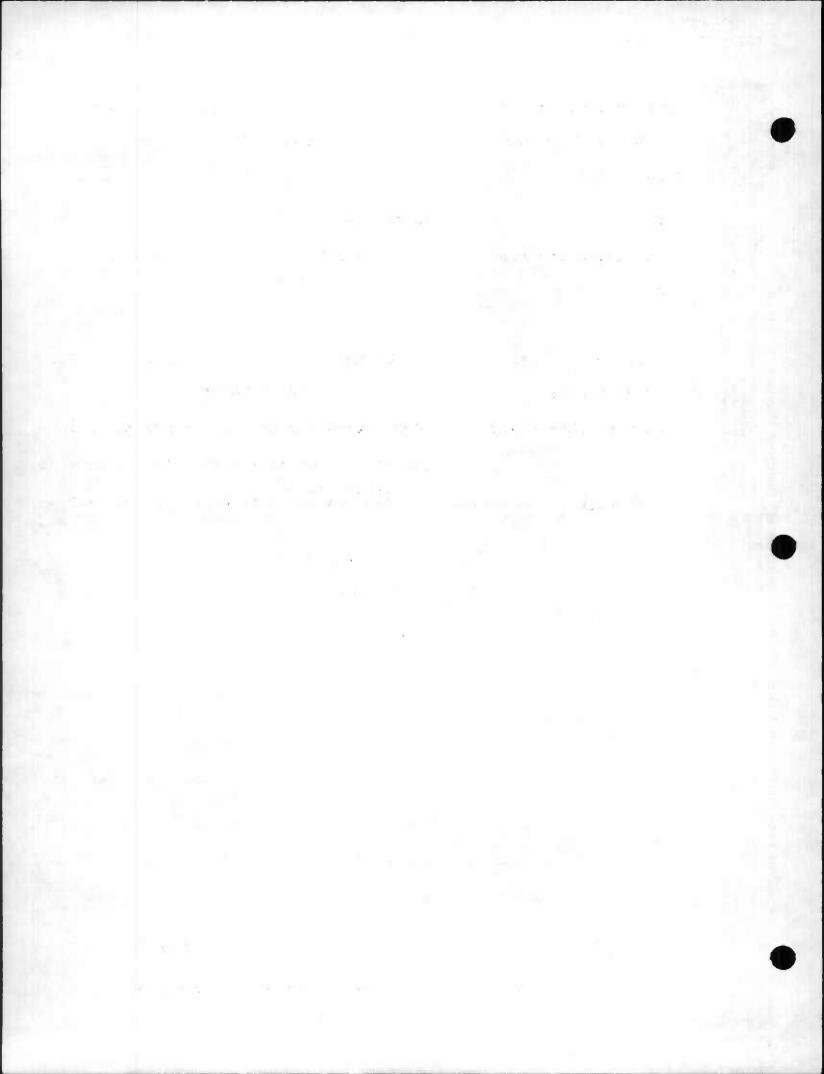
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) end manner stated. 29b. Signeture and title of pertifie

29c. License number O.C.M.E

29d. Date signed (Month, Day, Year) FEBRUARY 19,1999

30. Neme and eddress of person who complete luse of death (Item 23a) (Type, Print)

Street, Baltimore, Maryland 21201



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) February 11:55 pm Morrow ammy 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Johns Hopkins Bayview Medical Center Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) 5. Social Security Number 6. Sex Deys 10 M 20 F 34 214-80-9736 December 7 196 4 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of Whet Country? 2930 Yorkway Apt. B 21222 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American indien Bleck, White, etc. 11. Maritel Stetus 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Waitress 10 Restaurant 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Frank L. Jones Frances L. West 19a. Informent's Name/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Frances L. Kahlor/Mother 6800 North River Dr., Baltimore, MD 21220 20b. Pleca of Disposition (Neme of cametery, cremetory or other pleca) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriel 2 X Cremetion 3 ☐ Removel from State Green Mount Crematory 2-22-99 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22 Name end Address of Facility CAFA - Stephen D. Lohrmann, P.A. 8/1/ Green Pastures Dr., Ball 23a. Pert1. Enterthe disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 8717 Green Pastures Dr., Baltimore, MD 21286 Approximete Intervel Between Onset end Death immediate Cause (Final disease or condition resulting in deeth) Failure Respiratory 13 days Failure Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of): Gastrointestinal Failure IVER 23b. Did tobacco use contribute to the cause of death? Pert It. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Hepatitis 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 2XNo 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury et Work?

Physician /Medical **Examiner**

Physician

/Medical

Examiner

MD

Director

Funeral

py

Completed

Funeral

Director

with the Maryland

permit. Pegas 1 end 2 should be filed within 72 hours efter death with the Marylan Department of Heelth end Mental Hygiene.
Important: If item 27 is merked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at page.

altimore, Maryland 21215-0020

Examiner physicien end the burial-trensit Physician/Medical 88 USB for signed by the e by Completed 105

page 2 certificate After this funeral

Be

P

Certification:

Medical

1 Naturel

2 Accident 3 ☐ Suicide

4 Homicide

thet the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending Physician: after death. 24 hours a Hospital completely within 2 To the

5 150

29a. Certifier 1 Cartifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signature end title of certifier

5 Pending Investigation

6 Could not be determined

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number 29d. Dete signed (Month, Dey, Year) 04929

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

1 Yes 2 No

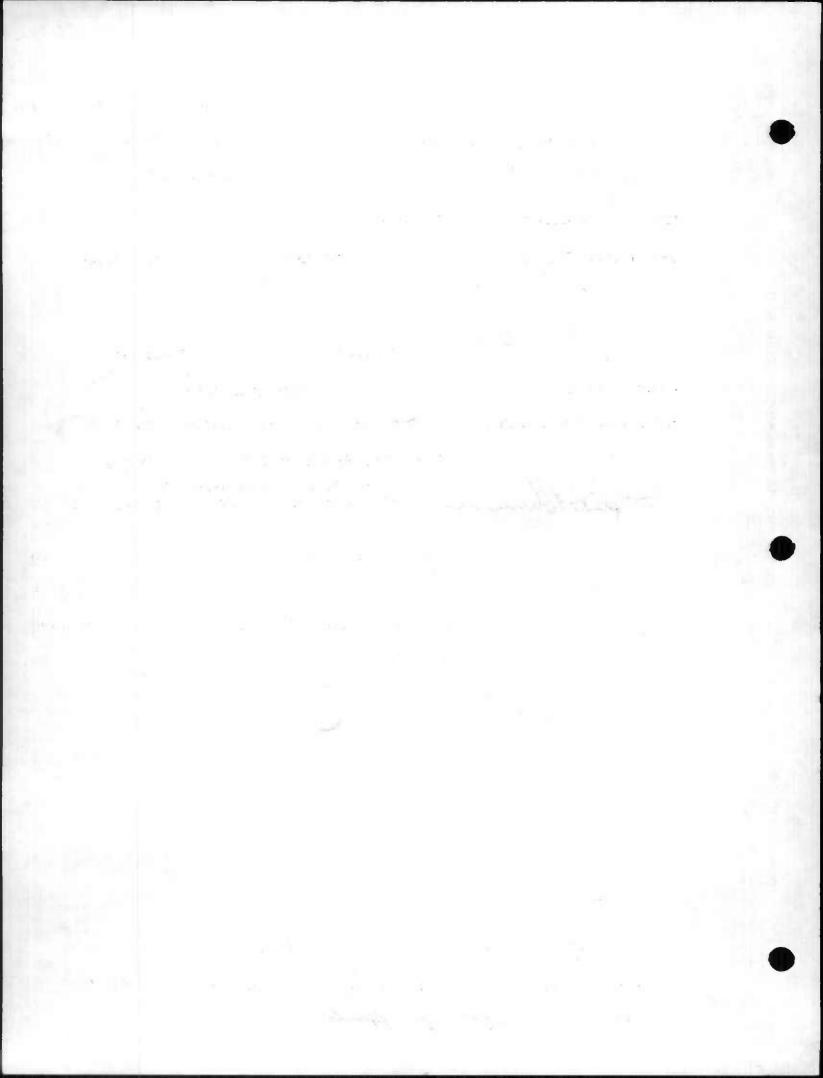
30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

MD

Johns Hopkins Baynew Medical Center Risa Sargeant. MD

31. Dete filed (Month, Dey, Year) FEB 2 3 1999 32 Registrer's Signeture

Registrar



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible.

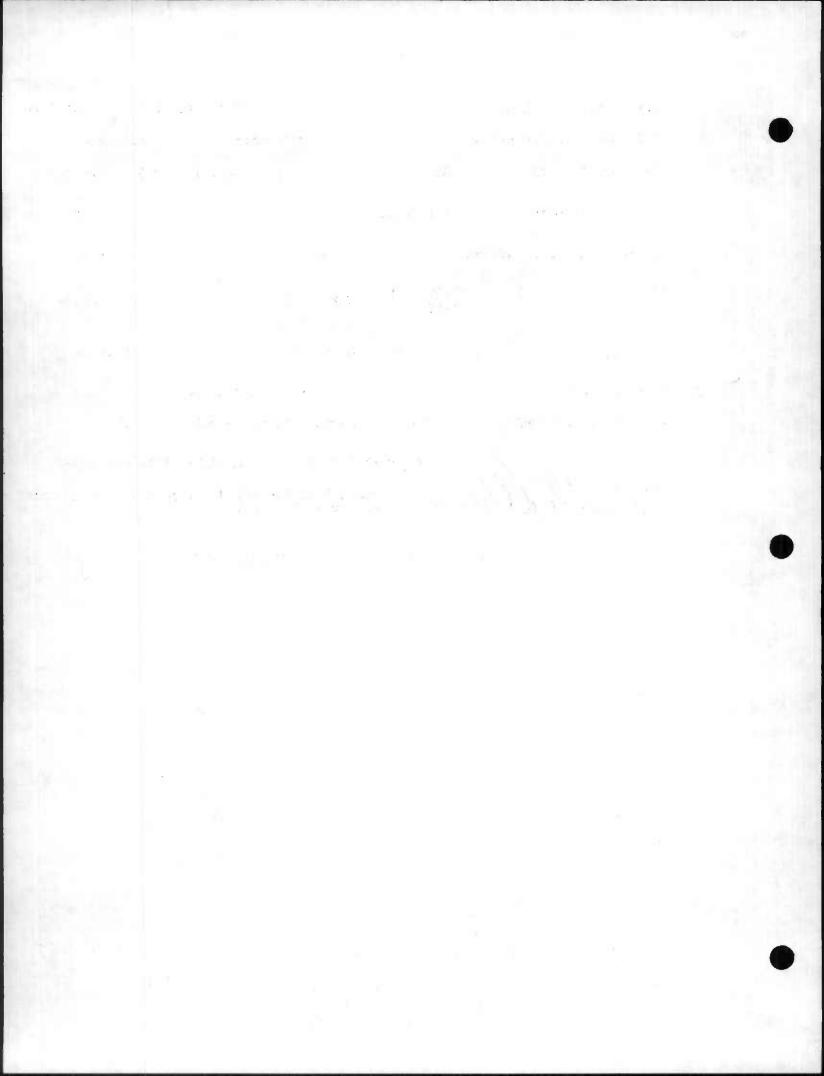
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death February 22, **Physician** 6:15 PM Mildred May Miles 1999 /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street and number) 4c. County of Death Examiner 8810 Walther Boulevard Apt. 1504 Baltimore Baltimore If Under 1 Year 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) May 29, 1918 5. Social Security Number 6. Sex If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 X F 80 Yrs. 220-09-0584 Baltimore, Md. Director Usuel Residence of Decedent the Manyland 10a. Stete 10b. County 10d. Inside City Limits 10c. City. Town or Location item 27 is marked other than "natural", or items 23a or 28a-f ahow other traumatic event, the Medical Examinar mast be notified at 1 Yes 2 No Parkville Baltimore Director Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21234 United States 8810 Walther Blvd. Apt. 1504 Funeral death 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11. Meritel Stetus Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If hem 27 is merked other than "natural", or her any Injury or other traumatic event. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lite. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Employment Agency Secretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Howard Clark Mary Sheeler 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2006 Poplar Ridge Rd. Pasadena, Maryland 21122 JanisM. Ripley (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 Cremetion 3 ☐ Removel from Stete 2/26/99 Towson, Maryland Hilltop Service Corp. 4 ☐ Donetion 5 ☐ Other (Specify) Knight Jr 22. Name and Address of Fecility Leonard J. Ruck, Inc. Funeral Home 21. Signature of Funerel Service Licensee Milton 5305 Harford Road Baltimore, MD 21214 23a. Pert1. Enter the disease of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failura. List only one cause change. Approximete Intervel Between Onset and Deeth **Physician** DUODENAL CANCER /Medical Immediete Ceuse (Finel 2 Mas disease or condition resulting in daeth) Examiner Examiner sician and burial-transit Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Ceuse (Disaese or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Records, P.O. Box 68760. physician certificate be Physician/Medical the Due to (or es e consequence of): as use l 23b. Did tobacco use contribute to the cause of death? the Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes A No 3 Probably 4 Unknown signed by ð 8 24b. Wara autopsy findings available prior to completion of cause of deeth? 24e. Wes en autopsy periormed? Completed peed has 24 No certificate 1 Yes 2 No Division of Vital 25. Wes case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA Other: 4☐ Nursing Home 5 Presidence 6 ☐ Other (Specify) To 1 Yes 2 000 this funeral 27. Manner of Death 28a. Data of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of al or Attending Pl s after death. Il Director: After th Certification: 28c. injury at Work? 1 Watural
2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 6 4 Homicide Hospital To the Hospital within 24 hours a To the Funeral C Tertifying Physician: To the best of my knowledga, death occurred at the tima, date and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at tha tima, data and place, and dua to the cause(s) and mannar stated. edical 29e. Certifier (Check only one) 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of certifies 027730 2/23/99 30. Neme end addrass of person who completed cause of death (Itam 23a) (Type, Print) CHAMES ST. BATO, MD 21204 COMEN 6569 MP N. 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State unen FEB 23 1999 Registrar

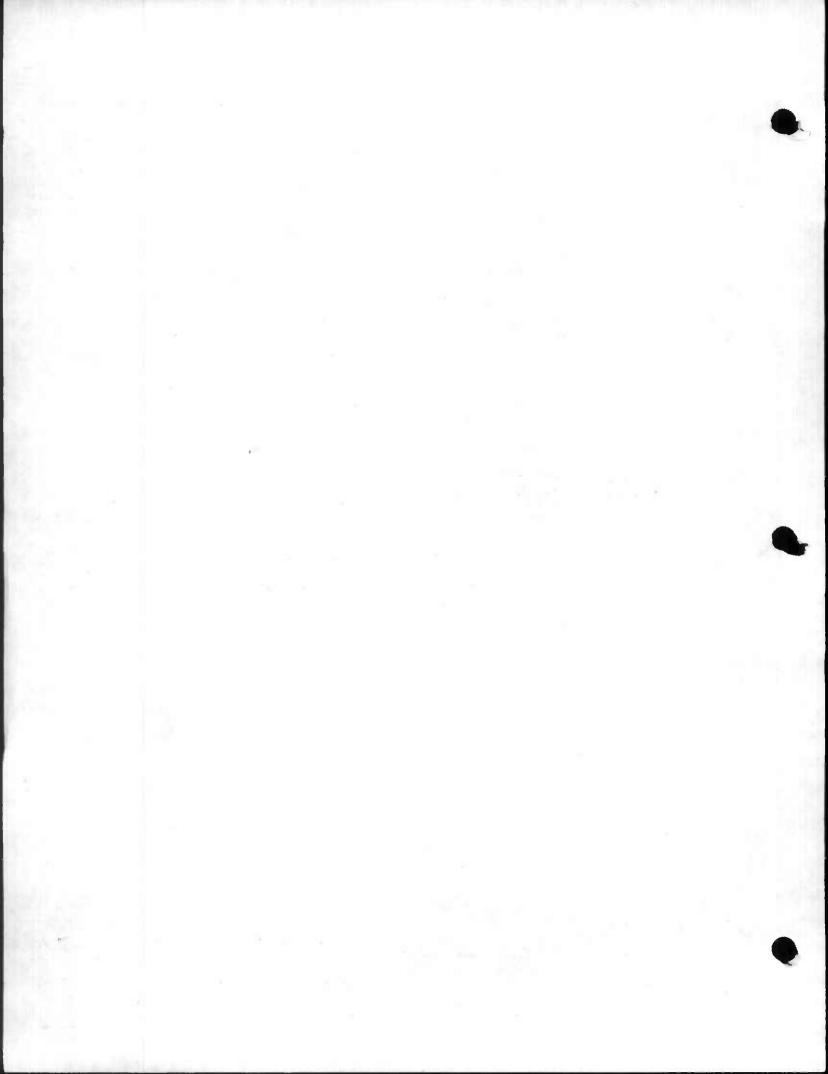
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

1. Decedent's Name	/Eiret Middle 1	*)		Ce	ertifica	te of	Death	1	2. Dete of De	Reg. No.	0.5	3. Time of Deeth	
Elmer	LeRoy Ma								Month Feb. 1	Dey	Year	7:00 am	
4a Facility Neme (If	4			cation of Deat!									
2405 West Patapsco Avenue											ltimo		
5. Social Security Nu 215-10-	9399 5	ex M 2□ F	7. Age (In yrs		Month:	er 1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, De Aug. 1	y, Year) 9, 1915	9. Birthp Cour Ma	irthplace (Stete or Foreign Country) Maryland	
Usuel Residence of 10e. Stete	Decedent 10b. County		10c C	ity, Town or L	ocation						1	0d. Inside City Limit	
MD Baltimore Baltimore												1X Yes 2 □ No	
10e. Street and Num					10f. Z	ip Code				10g. Citizen of	Vhat Cour	ntry?	
2405 Wes	t Patapso	o Ave	enue			21230)			United			
11. Maritel Status 1 Never Marrie 3 Widowed	Λ	Armed F	Armed Forces? 1x Yes, Give Armed Forces? 1 Yes, specify of the second			ecify Cubi	nt of Hispanic Orlgln? (Specify Yes or No- y Cuban, Mexican, Puerto Rican, etc.)				14. Race - American Indien, Bleck, White, etc. Specify: white		
	15. Decedent's Ed		Dates: 192	46 16a, Decedent's Usuel Occupation						16b. Kind of B			
(Special Elementery/Second	fy only highest greatery (0-12)	College (1-4or 5+) life. DO NOT use re				use retired	d) -	of worki	ng				
1:			0	C1	rane	Opera			450 - 441 - 4		Priv	ate	
17. Father's Name (Meiden Sumen	10)		
John Ma:		vne Print)		19b. Mai	lina Addre	ss (Street			y Hilt		Y lity or Town, Stete, Zip Code)		
	L. Marki		1						nburni		21061		
20a. Method of Disp	osition		20b.	Place of Disp cemetery, cre					Date	20c. Location			
	Cremation 3 15 Other (Specify		1 Stete	oudon I					2/18/9	9 Balt	imore	MTD	
22. Name end Address of Facility Loudon Park Funeral Home, 3620 Wilkens Ave Baltimore, MD 21229 Approximate the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, the disease, or heert failure. List only one cause on each line. Approximate thierval Beh Onset end to													
timmediate Cause (Final disease or condition resulting in death) a. metastatic head + neckcepncer Due to (or es a consequence of):												years	
Sequentially list con if any, leading to im- ceuse. Enter Under	ditions, mediate lying	b	Due to	or as a conse	equence o	f):							
Cause (Disease or li that initieted events resulting in death) L		Due to (or as a consequence of):											
D													
Pert II. Other signific	cant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of d				
										24a. Wes an autopsy performed?		ere autopsy findings reileble prior to impletion of cause death?	
									10	Yes 2 No	11	Yes 2016	
25. Was cese referre	-	11 1				100		of Death	(Check only	one)			
1 Yes 2 SX1 27. Menner of Deeth 1 XNaturel 2 Accident	5 Pending	28a. Date (Mo		28b. Time Injury	b. Time of 28c. Injury Wor		Other: 4 Nursing Home !		-	5 Residence 6 Other (Specify) 5. Describe how injury occurred		(y)	
3 Suicide 4 Homicide	6 Could not be determined								28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	Certifying Phy	Iner: On the I											
29b. Signature and t	tie of certifier	/	10		2	9c. Licens	e number			29d. Date signe	d (Month,	Dey, Year)	
19/1	Who	ml	ele.	mo		Da.	520.	5	1	Februa	141	4,1999	
30. Name and address of person who cumulated cause of depth (Hern 23a) (Type, Print) WAR (ley GAMC 6701 N-ChipMes St. Balto Md 2120x													
WAR	ley GB	he	0670	I N.	Chip	les .	St. 1	BAL	to M	d 2120	Se		



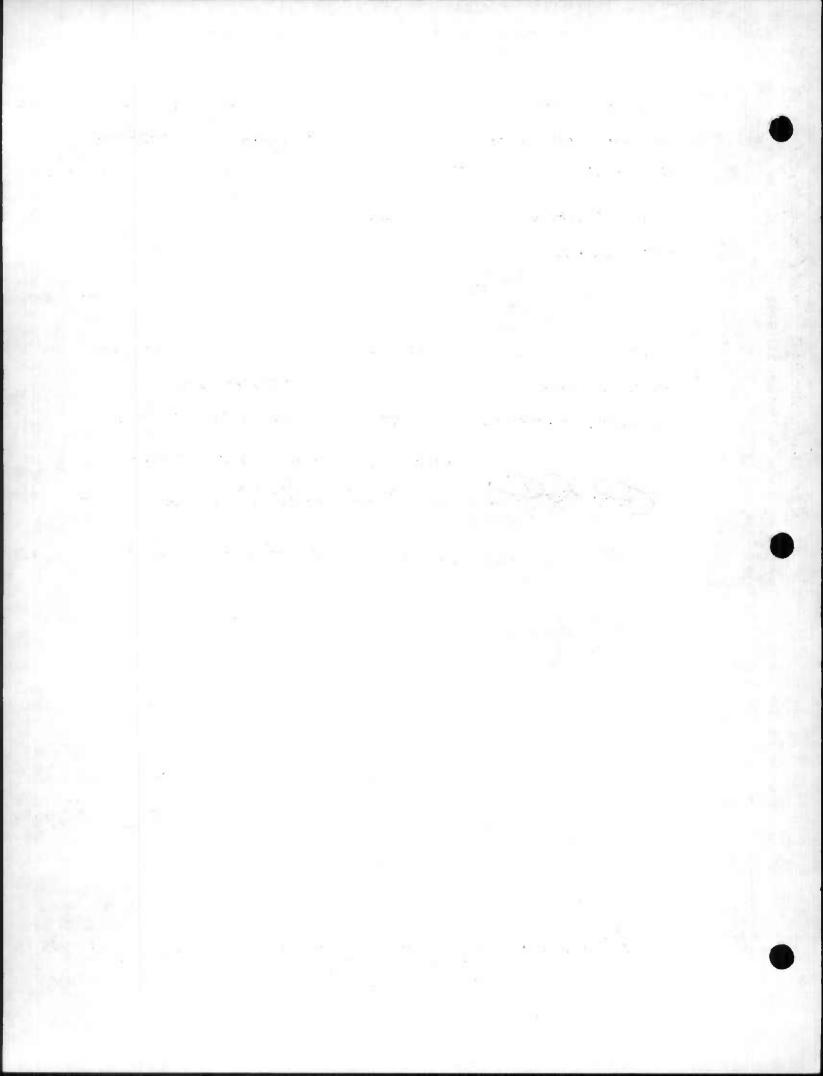
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St. Joseph Social Security Numb 55-34-5842 Jsual Rasidence of De	Jose institution, giva Medica er 6. Se	ph M street and number)	iele				Month Februar	Day 21, 19	Year 999 1	0:41PM			
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St. Joseph Social Security Number 55-34-5842 Jaual Rasidence of De Oe. State	Medica er 6. Se	2010 1-5000	4a Facility Nama (If not institution, give street and number)					h 4c. County		U.41FF			
. Social Security Numb 55-34-5842 Jsual Rasidence of De 0a. Stata 10	er 6. Se	St. Joseph Medical Center						io. oom,					
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Jsual Rasidence of De Oa. Stata 10		JM 2□F	57	Yrs.	Months Days	Hours Min.	8. Data of Bir (Month, Da	19, Year)	Country)	wle			
	edent						rial Cii 1	17, 1741	New 10	IK			
MD	b. County		10c. City, T	own or Loc	ation				10d. Ir	nside City Limits			
Turkeon Turkeon													
0e. Street and Numbe				100011	10f. Zip Code			10g. Citizen of V	Vhat Country?				
l614 Rayvil	1a Road				2112	0		US	2 A				
1. Marital Status	.Te_Road	12. Was Decedent I	Evar in U,S.	13. W		Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yas or No		e - American In	dian,			
1 Never Married 3 Widowed 4		Armed Forces? 1 🖾 Yas 2 📗 N If Yas, Giva Year or Datas:		Yas, specify Cul ☐ Yas 2(X) No		> Rican, etc.)		k, Whita, atc. White					
15.	Decedent's Edu	cation	16a. Decedent's Usual			pation		16b. Kind of Bu	sinass/Industry	,			
			lifa DO NOT use n			auring most of worked)	ring						
Elementary/Seconds	y (0-12)	Collega (1-4or 5)+)	Elect	ronic T	echnician		E1e		ics			
7. Father's Nama (Firs	t, Middla, Last)					1							
Michele M	liele					Lou	ise Se	iler					
		rpe, Print)		19b. Mailing	Address (Stree				State, Zip Cod	9)			
onna J. Mi	ele/ Wi	fe											
Oa. Mathod of Disposit	ion		20b. Place	e of Dispos	ition (Nama of		Date Date			Stata			
			Dulan	ey Va	lley Me	morial F	Feb. 25,						
			Garde				1999	11mon1	um, MD				
N CO	2	9					of Dul	anev Val	lev. In	nc.			
Mich	ael J.	Blagle		10	W. Pado	nia Road	Timoniu	m, MD 21	093				
23a Furtherntar tha d	sease, or compli lura. List only or	ications that caused na cause on each lir	tha death. [ne.	Do not anta	r tha moda of dy	ing, such as cardiac	or raspiratory a	rrest,	Inte	roximata rval Batween			
		14.							Ons	et and Death			
Immediate Causa (Final disease or condition resulting in death) a. VENTRIBUL AR PLANILLAS IX III													
Dua to (or as a consequence of):													
		LEF)	TVA	and	- 11/	SKUN	00xx	L	i	XXX			
Sequentially list conditi	ons,	Dua to (or as a consequence of):											
cause. Enter Underlyin Ceuse (Disease or inju-	nderlying c												
that initiated events resulting in death) Last Dua to (or as a consequence of):													
Ceuse (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): d									į				
art II. Other significan	t conditions cor	tributing to death bu	to death but not rasulting in the underlying cause given in Part I.					23b. Did tobecco use contribute to the cause of					
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5. Was case refarred	o medical					26. Place of Dea	th (Check only	one)					
1 Yas 2 No	1	lospital:	nt 2 ER	/Outpatient	3 DOA	ther: 4 Nursing H	oma 5 ☐ Rasi	dence 6 Oth	er (Specify)				
				b. Tima of									
2 Accident	☐ Pending invastigation	process, conj		101 9									
	Could not be datarmined	28a. Place of Inju	ury - At homa	, farm, stre	et, factory, office				er or Rural Ro	ıta Number,			
- Li Homicoa		building, etc	. (Specify)				Ony Or TO	wii, Sididj					
29a. Certifier 1K	Certifying Phys	ician: To the best of	my knowled	dge, deeth	occurred at tha	ima, deta and place	, and due to tha	cause(s) and ma	nner as stated				
(Check only cone) 2									and due to the	CaUSe(S)			
9b. Signatura and the	of continue	1/1/		114135	-		~ ~ \						
1/8	V U	110	-	m	60	2000	62	2	-23.	-77			
0. Nema and addrass	of person who co	mpleted causa of de	eath (Item 23	a) (Type, P									
					*								
Richard D.	Biggs N	1.D. 750'	5 ()sle	r Dri	ve Balt	imore, MD	21204						
	(Specify of Elementary/Secondary 17. Fathar's Nama (First Michele Michele Miga. Informant's Name (Donna J. Michele Miga. Informant's Name (Donna J. Michele Miga. Mathod of Disposit 1 Michele Miga. Michele M	(Specify only highast grad Elementary/Secondary (0-12) 17. Fathar's Nama (First, Middla, Last) Michele Miele 19a. Informant's Name/Ralationship (Ty) Donna J. Miele/ Wi 20a. Mathod of Disposition 1	17. Fathar's Nama (First, Middle, Last) Michele Miele 19a. Informant's Name/Ralationship (Type, Print) Donna J. Miele/ Wife 20a. Mathod of Disposition 1 Burial 2 Cremation 3 Removal from Stata 4 Donation 5 Othar (Specify) 21. Signature of Europial Service 23a. Purt Entart the disease, or complications that caused whock or heart failura. List only one cause on each life 1 and disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying 2 and 1 and	Elementary/Secondary (0-12) College (1-4or 5+) 3 17. Father's Nama (First, Middla, Last) Michele Miele 19a. Informant's Name/Ralationship (Type, Print) Donna J. Miele/ Wife 19a. Informant's Name/Ralationship (Type, Print) Donna J. Miele/ Wife 19a. Mathod of Disposition 1	College (1-4or 5+) College (1-4or 5+) Electric	Comparison of the property o	College (1-4or 5+) College (1-4or 5+) Elementary/Secondary (0-12) College (1-4or 5+) Electronic Technician 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nam (First, Middle, Last) 18. Mothar's Nam (First, Middle, Last) 19. Mailing Address (Street and Number or Plu Jounal of Disposition 19. Mailing Address (Street and Number or Plu Jounal of Disposition 19. Mailing Address (Street and Number or Plu Jounal of Disposition 19. Mailing Address (Street and Number or Plu Jounal of Disposition 19. Mailing Address (Street and Number or Plu Jounal of Disposition 19. Mailing Address (Street and Number or Plu Jounal of Disposition 19. Mailing Address (Street and Number or Plu Jounal of Disposition 19. Mailing Address (Street and Number or Plu Jounal of Disposition (Nama of Cematary, Ceramatory or Other Place) 19. Mailing Address (Street and Number or Plu Jounal of Disposition (Nama of Cematary, Ceramatory or Other Place) 19. Mailing Address (Street and Number or Plu Jounal of Disposition (Nama of Cematary, Ce	Give kind of work done during most of working life. Do Not ruse nettering life. Do N	Common C	Comparison Com			



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Daath 1. Decedant's Nama (First, Middla, Last) 3. Time of Death Day 1999 **Physician** Feb. 18 2:38 pm Margaret C. Muller /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Baltimore Gilchrist Hospice Care Baltimore 8. Data of Birth (Month, Day, Yaar) If Undar 1 Yaar If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Days Hours 1 M 2 F Yrs. 79 138-18-7361 Director March 1 1919 New Jersey Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. insida City Limits 1 Yas 2 No Baltimore Baltimore MD Director 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda USA 21204 1902 Ruxton Road Funeral 12. Was Decedant Evar in U,S. Armad Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - American Indian, Black, Whita, atc. 1 Yas 2 No If Yas, Give Yaar or Datas: 1 Navar Marriad 20 Married 1 Yas 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorcad Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Spacify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) WIER, Margoret Librarian Library 18. Mothar's Nama (First, Middla, Maiden Surneme) 17. Fathar's Nama (First, Middla, Last) Nellie May Savidge Nathan W. Clayton 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 1902 Ruxton Road, Balto., MD 21204 f Health flors 27 i Paul Muller, Jr./husband 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1X Burial 2 Cramation 3 Ramoval from Stata 2/22/99 Pikesville, MD 4 Donation 5 Othar (Specify) Druid Ridge Cemetery 22. Nama and Addrass of Facility Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093 Michael Flagle Part . Ther tha diseasa, or complications that causad tha daath. Do not antar tha mode of dying, such as cardiac or respiretory arrest, shock, or heart tailure. List only one cause on each line. Approximate Intarval Batwaan Onsat and Death **Physician** phic lateral Sclerosis /Medical Immediata Causa (Final disaasa or condition resulting in death) Examiner Examiner certificate be axecuted attending physician and for use es the buriel-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avents rasulting in daath) Last Dua to (or as a consequence of): P.O. Box 68760, Physician/Medical Dua to (or as a consaquanca of): 23b. Did tobecco use contribute to the cause of death? Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yas 2 XNo 3 Probably 4 Unknown 2 Division of Vital Records, p 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death? Completed certificeta hes b 2 No 1 ☐ Yas 2 ☐ No 25. Wes case ratarred to medical exeminer? Be 26. Placa of Daath (Check only one) To Othar: 4 Nursing Homa 5 Rasidanca 6 Nothar (Specify) 1 Yas 2 No 1 | Inpatiant 2 | ER/Outpatient 3 | DOA unerai 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Time of 27. Mannar of Death 28c. Injury at Work? After 1 Natural 5 Panding invastigation eftar death. 1 TYas 2 No 2 Accident 6 Could not be detarmined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) Placa of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 3 4 Homicide 24 hours 1 Certifying Physicien: To the best of my knowledga, daath occurred at tha tima, data and place, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and dua to the cause(s) and manner stated. edicai 29a. Cartifiar completely (Check only one) To the within 2 29d. Data signed (Month, Day, Year) 29b. Signature and un of person who completed cause of Math (Itam 23a) (Type, Print) N. Charles St. Balto. Md 21204 6701 10 32. Registrar's Signatura State Registrar **DHMH 16 Rev 6/95**



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1 Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Death Day Month **Physician** 7 20 97 EDWARD STANLEY MacDONALD 12:00 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number, 4c. County of Death Examiner Baltimore City Genesis Eldercare: Long Green Center N/A If Under 1 Year 7. Age (In yrs. lest birthdey, Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F Months Days Hours Min. Yrs. 92 Director May 2, 1906 Washington 558-09-8277 Usual Residence of Decedent with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits r than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Baltimore County Ruxton Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1004 Malvern Avenue 21204 USA 14. Race - American Indian. death 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or iten eny injury or other traumatic event, the Medical Example. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White by 3 ₩ Widowed 4 Divorced Completed 15. Decedant's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Etementery/Secondary (0-12) College (1-4or 5+) 12th Printing Foreman Printing 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Nellie. 10 Emil 01son Sandness 19a. Informant's Name/Retationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Robert MacDonald 20b. Place of Disposition (Name of cametery, cremetory or other place)

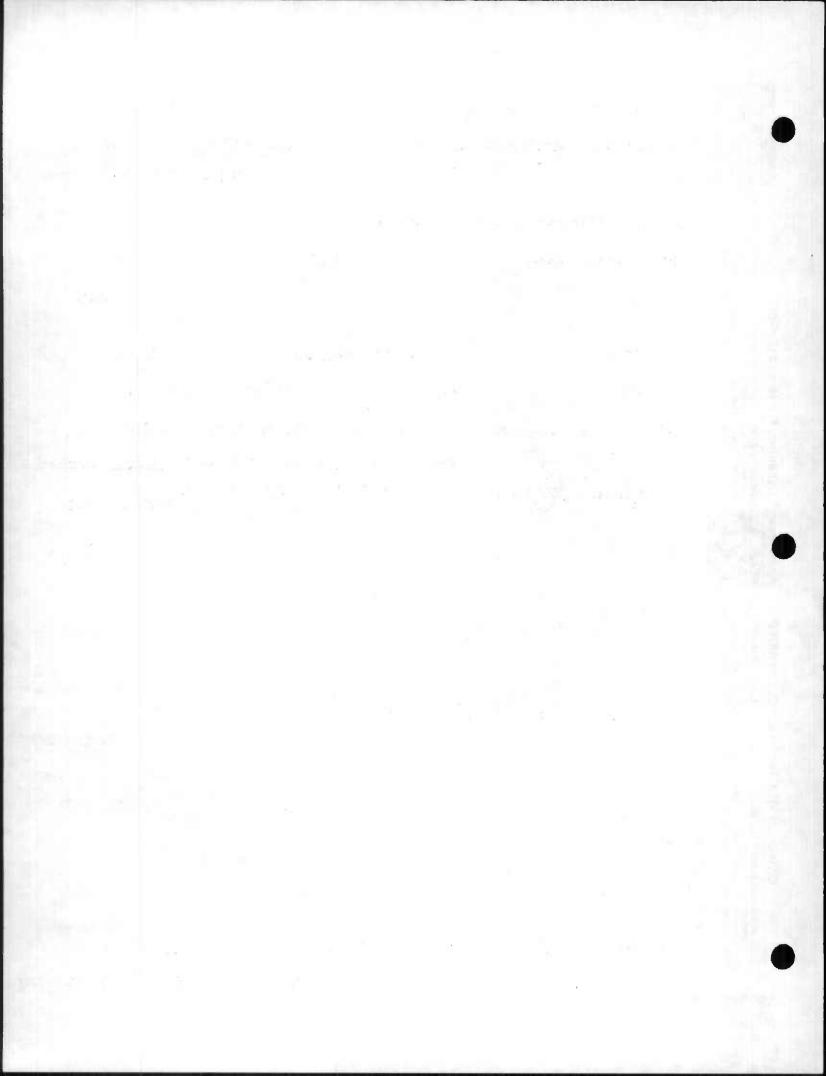
Ruxton, MD 21204

20c. Location - City or Town, State (Son) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/22/99 Baltimore, Maryland Green Mount Crematory 21. Signature of Funeral Sarvice Licensee

Martin D. Lawson 22. Name and Address of Facility Mitchell-Wiedefeld Home, Inc. Martin D. Lawson 6500 York Road, Baltimore, Maryland 21212

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 100 Proximately 100 P awson Approximate Intervet Between Onset and Death **Physician** Preuminia Immediate Ceuse (Final disease or condition resulting In death) /Medical Day S Examiner Due to (or as a consequence of): Physician/Medical Examiner ettending physician and for use as the buriel-transit The law requires that the death certificate be speculed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Due to (or as a consequence of): 80 23b. Did tobacco use contribute to the cause of death? ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed t hrmic Division of Vital Records, þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed peed completion of cause of death? hes page 1 Yas 20 No 1 ☐ Yes 2 ☐ No certificate Physician: Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 ☐ Rasidanca 6 ☐ Othar (Specify) 1□ Yes 2☑ No P After this 28a. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred Certification: 27. Menner of Deeth 28c. tnjury at Work? or Attending Netural 5 Pending investigation 1 Yes 2 No deeth. 2 ☐ Accident i Director: / 6 Coutd not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide efter Hospital 24 hours edicai 29a. Certifie + Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) end menner es stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signatura and titla of cartifiar 29c. Licansa number 29d. Data signed (Month, Dey, Year) 2-20.99 D23076 Wer 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3730 Folls RD Bull Md 7/211 SICH APPO DIAMOND 32. Registrar's Signatura 31. Date filed (Month, Day, Year) State 1999 FEB Registra



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Deeth 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Day Month Physician Oscar Albert Meyers February 13 1999 10:42 PM /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Name (If not institution, give street and number) Examiner Good Samaritan Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2□ F 212-07-1894 89 Yrs. Director November 9 1909 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experient must be notified as 1 Yes 2□ No Maryland N/A Baltimore Directo 10a. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 318 St. Dunstans Road 21212 United States permit. Pages 1 and 2 should be filed within 72 hours efter deeth v Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medeal Examiner mans once. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 14. Raca - American Indian. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 X No Specify: Specify: þ White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) President Liquor Distribution 4 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Mary Ann Weber Oscar Albert Mevers 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oscar Albert Meyers III / Son 318 St. Dunstans Road Baltimore, Maryland 21212 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removel from State 2-17-99 Woodlawn, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Lorraine Park Cemetery 21. Signature of Funeral Service Licenses 22. Name end Address of Facilit Mitchell-Wiedefeld Home, Inc. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, Approximately 110118, 1118. Approximately 110118, 1118. Approximately 110118, 1118. Approximete Interval Between Onset end Death **Physician** /Medicai Immediate Ceuse (Final disease or condition resulting in death) Pneumonia 2 weeks **Examiner** Due to (or es a consequence of): Physician/Medical Examiner Cholecvstitis 2 weeks Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequenca of): that initieted events resulting In death) Last Due to (or es e consequence of): 98 1 signed by the eld be detached for 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Cardiomyopathy þ 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Was en eutopsy Completed peed : Abdominal Aortic Aneurysm pege 2 certificate has 1 Yes 2 No 1 ☐ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) s ofter death. I Director: After this ce Hospital: 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1º 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated edical (Check only 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartified

Registrar

Charles R. Zerez, M.D. 31. Date filed (Month, Day, Year) FEB 2 3 1999

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

32. Registrar's Signature ner

ronor

050958

2014 Tollgate Road Suite 200 Bel Air, MD 21015

Feb. 15, 1999

DHMH 16 Rev 6/95

The law requires that the deeth certificate or an

Physician:

or Attending

Hospital

Division of Vital Records, P.O. Box 68760,

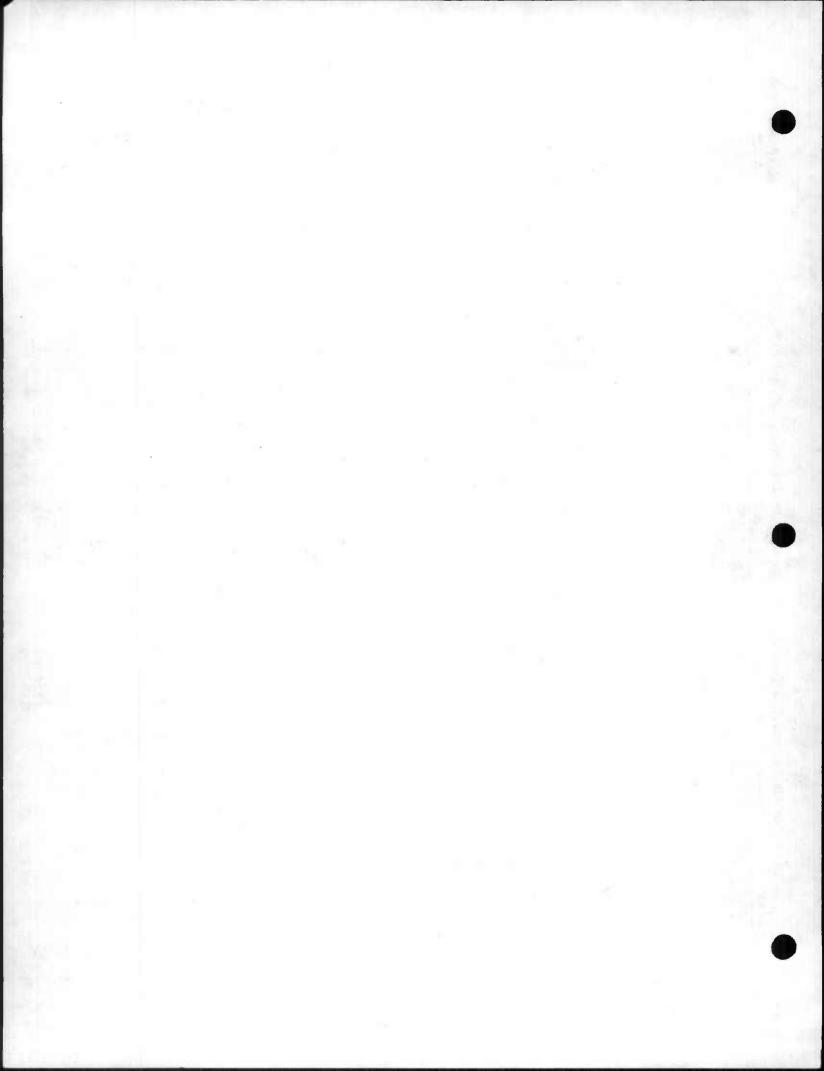
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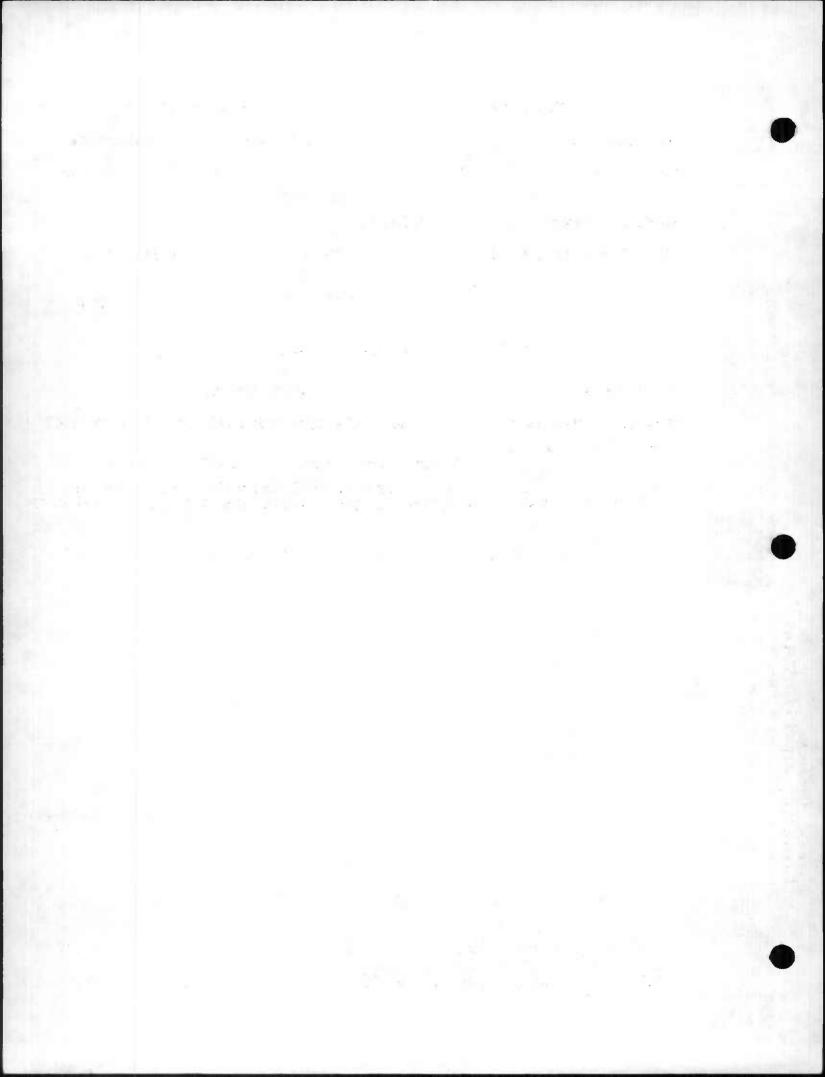
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Clarence Massey Sr. 20, Feb. 1999 5:00am /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 890 Claffy Drive Gambrills Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Deys Hours 1⊠M 2□F 76 Yrs. 1922 Director 246-26-0086 Nov. 16, North Carol Usual Residence of Decedent ina 10b. County 10e. Stete 10c. City, Town or Location 10d. Inside City Limits ehow. ral", or items 23a or 28a-f shore Examiner must be notified at MD Anne Arundel Gambrills 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 890 Claffy Drive permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hydene. Important: if item 27 is marked other than "natural", or items 23a any Injury or other treumetic event, the Medical Example page. 21054 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Black, White, etc. 11. Meritel Stetus 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) State of Maryland Psychiatric Aid 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Luther Massey 20 Essie Ruffin 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tempie B. Massey - Wife 890 Claffy Drive, Gambrills, MD 21054 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20e Method of Disposition 20c. Location - City or Town, State Date Burial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 02/23 Crownsville, MD 22. Name end Address of Fecility
Hardesty Funeral Home, P.A. 21. Signature of Femoral Service License also 12 Ridgely Ave. Annapolis, MD 21401 23a. Pert1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) **Examiner** Examiner Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Box 68760. Physician/Medical the Due to (or es e consequence of): P.O. Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by Sign 24e. Wes an eutopsy performed? 24b. Were eutopsy findings available prior to Completed pinous completion of cause of death? page 2 1 Yes 2 No 1 Yes 2 No Division of Vital Attending Physician: Be 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Natural 5 Pending 1 Yes 2 No death. 2 Accident investigetion hours effer death uneral Director: 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, Iarm, street, fectory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 6 filled in Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end plece, end due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) within 2 eg E 29b. Signeture and file bl certifier 29c. License number Name end address of person who completed cause of death (Item 23a) (Type, Print) CM 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar 1999

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Nikolaos Mangos 1999 0200 Februar 20 4e Fecility Name (If not Institution, give street and number) Town, or Location of Deeth Baltimore Hopkins HOSPITAL Minder 1 Year Johns n/a Birthplece (State or Foreign Country) 5. Sociel Security Number 6 Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dev. Yeer) MIM 2□ F Months Deys Hours 12/05/1938 218-56-9645 60 Greece Usuel Residence of Decedent 10a, Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No A.A.Co. Md. Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? USA 1184 Ramblewood Dr. 21401 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indien Bleck, White, etc. 1 □ Never Married 2 □ Married 1 Yes PNo Specify: Specify: Greek 3€Widowed 4 □ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Self Employed Baker 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Neme (First, Middle, Last) Skebos Mangos Katina Gonatou 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Katina Christodoulou/daug. 24-02 21st. Street, Astoria, NY 11102 le. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State Kalymonos, Greece 4 ☐ Donetion 5 ☐ Other (Specify) Agia Vassili Fm. Plot 2/28 21. Sumature of Funerel Service Licansee 22. Neme end Address of Fecility James A, Morton & Sons Funeral Home Inc Times 23a P. rt1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximate shock, or heart feilure. List only one cause on each line. Intervel Between Onset end Deeth Immediate Ceuse (Finel disease or condition resulting in deeth) fa. lura liver years Due to (or as a consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es e consequenca of): 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Per. bar. b. s Backer: al Sportancous 24b. Were eutopsy findings evailable prior to 24a. Wes en eutopsy performed? Kidney disease completion of cause of deeth? 1 ☐ Yes Mo 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpetient 3 □ DOA 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work?

Physician /Medical **Examiner** certificate be axecuted

Physician

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permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylen Department of Health and Mentel Hyglena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show say injury or other traumatic event, the Modical Examinet must be notified at once.

altimore, Maryland 21215-0020

P.O. Box 68760

Division of Vital Records,

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Hospital of 24 hours e

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Examiner Physician/Medical þ Completed Be Certification: To

25. Wes case referred to medical examiner? 1 Yes 2 No 27. Manner of Deeth 5 Pending Investigation Naturel Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Excartifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier

29c. License number

1 Yes 2 No

29d. Dete signed (Month, Dey, Year)

RES-OC

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

1999 tobruar 20

30. Name and audiess of person who completed cause of deeth (Item 23e) (Type, Print)

St Rm 9020 Ballsmare, MD 1830 E. Monumert 21205 TAYLOR JSTEK (31. Date filed (Month, Dey, Year)

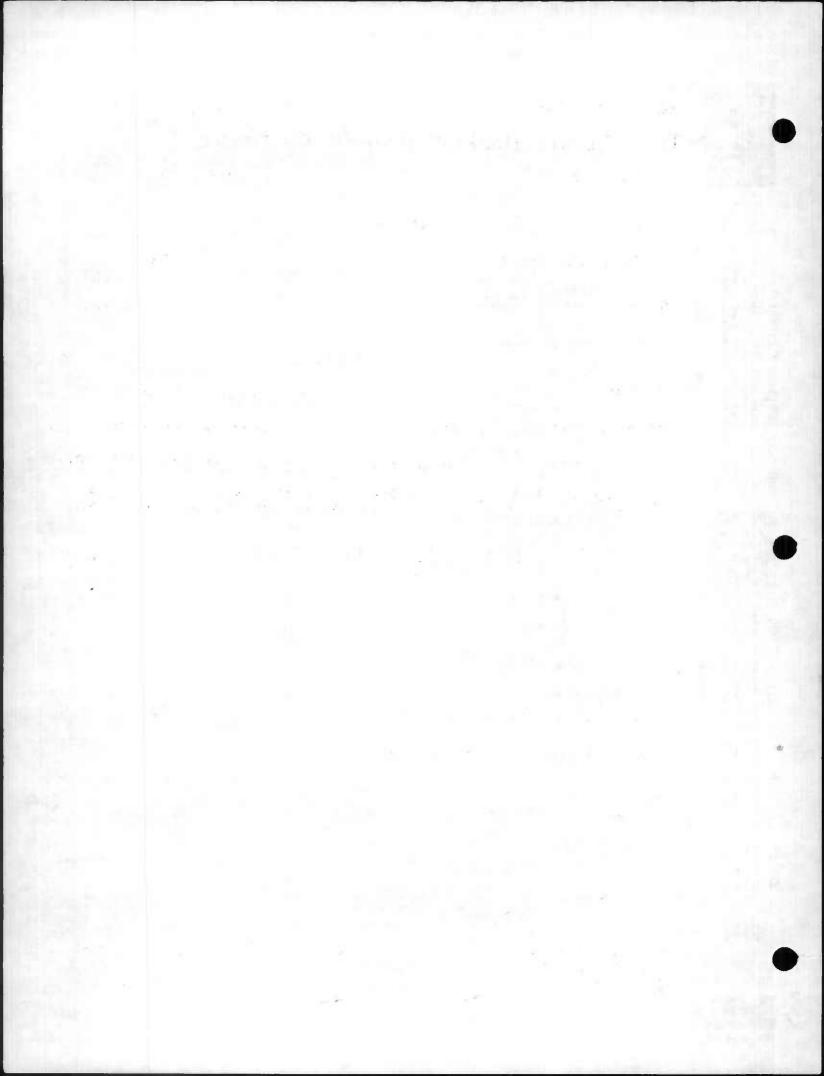
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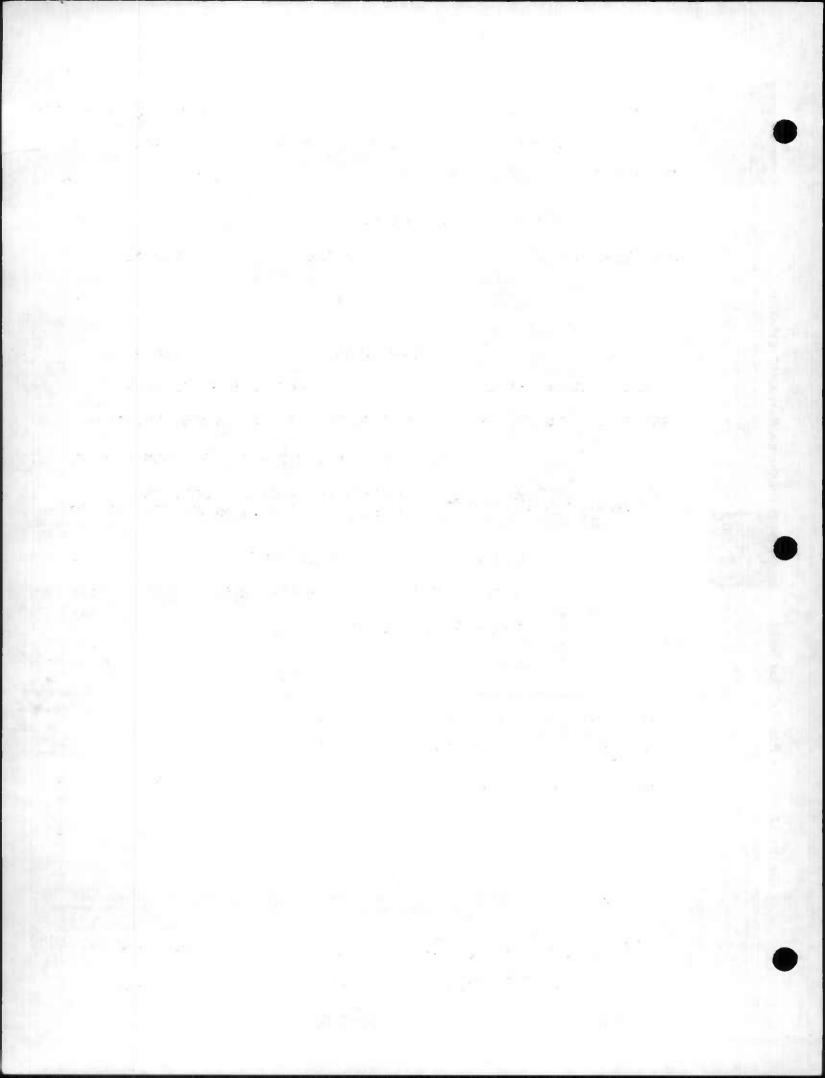
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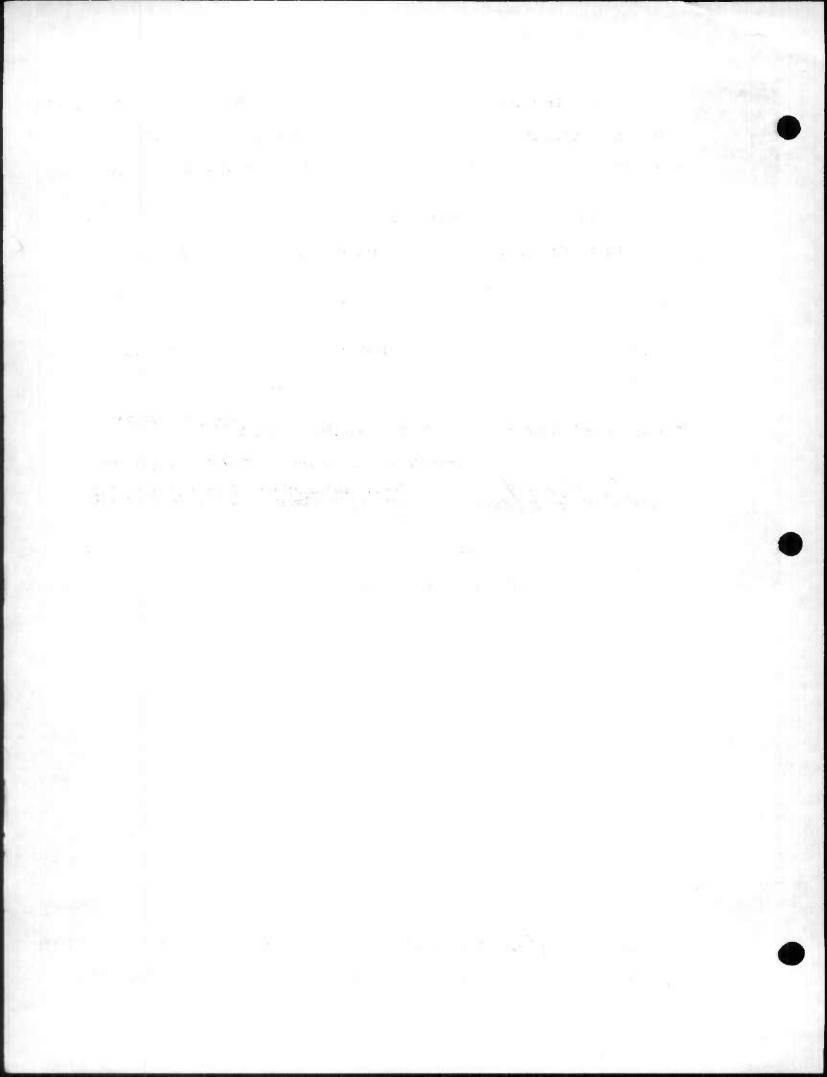
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F	20a. Mathod of Disposition				lace of Dispo emetery, cra	osition (N	ama of	ce)	Dat	a 20	c. Location -	City or Town,	Stata
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ineral rector		5. Social Security 290-14-30	058	3. Sex 1 □ M 2/□ F	7. Age (In yr. 86	rs. last birthday) Yrs.	Months Dey			th 1912	9. Birthple Count Un K	ace (State or Fo
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tant:		4 Donetion	5 ☐ Other (Spe	ecify)			sh. Crem		2/19/99	Laure	el, MD	
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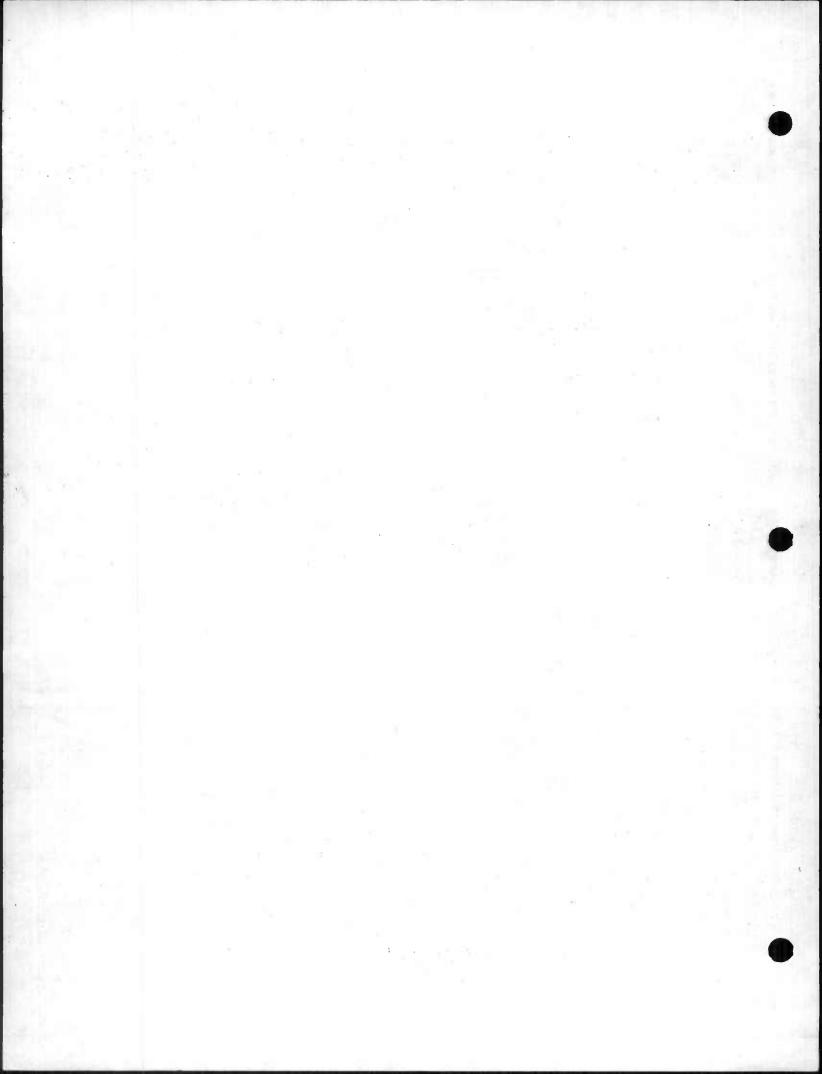
State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Robert Mangle February 16, 1999 7:00 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Baltimore City Joseph Richey Hospice Baltimore H Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 7, 1921 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1₽M 2□F 257-48-2941 Yrs. Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore City Baltimore 10a. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8 must be 1519 N. Bethel Street 21213 U.S.A. "natural", or flerns 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black White etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black 3 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b, Kind of Business/Industry Hygiens. Elementery/Secondary (0-12) College (1-4or 5+) unknown unknown Brick Layer Construction permit. Pages 1 and 2 should be filed Department of Health and Mental Hygii Important: If Item 27 is marked other any injury or other traumatic event. It 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lonnie Shanks Lizzie Clark 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debbie Mangle/wife 1004 Bonaparte Street, Baltimore, Maryland 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Ronald S 22. Name and Address of Fecility Wade Director State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Plrt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, slipck, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Final arcinoma Lung / mouth disease or condition resulting in deeth) Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 | No 3 | Probably 4 | Unknown g 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed 1 Yes 2 ₽No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) #05/100 Division of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending death. 1 Yes 2 No investigation 2 Accident To the Hospital or Attend within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 29e. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of coulding 29c. License number 29d. Date signed (Month, Day, Year) rolles 2-16-99 30. Name and address of person who completed cause of death (flem 23a) (Type, Print) 828 N. Entawst. Balto. Md 21201 Lrwin MD KOBELT C 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

FEB 2 2 1999

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** ICHOL TLEGO 02 1730 19 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner COURS HOSPITAL BALTIMORE SE 7. Aga (In yrs. last birthday) If Undar 1 Yaar 8. Data of Birth (Month, Dey, Year) 5 Social Sacurity Number 6. Sax 9. Birthplaca (Stata or Foraign **Funeral** 10 M 20 F Months Deys 715-50-8062 Marylano Director Usual Rasidenca of Dacadant the Maryland 10a Stata 10b. County 10c. City, Jown or Location 10d. Insida City Limits 7 is marked other than "naturef", or items 23a or 28a-f show trsumstic event, the Madical Examinar must be notified at 1 Nas 2 No Director 0 imore 10e. Street and Number 10f. Zip Code 10g. Citizan of Whet Country? permit. Peges 1 and 2 should be filed within 72 hours efter death with ti Department of Health and Mental Hygiene. Important: If item 27 is merked other than "naturel", or items 23a or 2 withingry or other treumstic event, the Medical Examiner must be mades. 4100 217 NOOC 1. Sr. A 14. Race - American Indian, Funeral Was Decedant Evar in U.S. Armed Forces?
1 Yas 2 0 100 If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puerto Rican, atc.) 11. Marital Status Black, Whita, atc. 1 Nevar Married 2 Married 1 Yas 2 No Spacify: Baltimore, Maryland 21215-0020 Black à 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Elementary/Secondary (0-12) College (1-4or 5+) Tax. Nebo 18. Mothar's Nama (First, Middle, Majden Sumama) 17. Fathar's Nema (First, Middla, Last) Be C Blackhers Li Nicho 15 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Informant's Name/Raletionship (Type, Print) Fewher 360 S s treet berr 20b. Place of Disposition (Nama of cematery, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funtiral/Service Licenses 22. Nama and Addrass of Facility 639 Miller funera the the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** Immediata Causa (Final disaasa or condition resulting in deeth) /Medical Facture Examiner Physician/Medical Examiner 16 physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata ceusa. Entar Undarfying Ceuse (Disaasa or injury that Initiated avants rasulting in deeth) Last Due to (or as a consaquance of): Renal Division of Vital Records, P.O. Box 68760, Dise ese Sta Dua to (or a salconsequance of) 88 tenscon DEV nse signed by the a d be detached f 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 3 Probably 4€ Unknown 1 ☐ Yes 2 ☐ No Ď 24b. Were eutopsy findings available prior to 24a. Was an autopsy Completed complation of ceusa of deeth? certificate has b lirector, page 2 s 2/X No 1 ☐ Yas 2 ☐ No al or Attending Physician: The safter death.

In Director: After this certificated in by the funeral director, pages. 25. Was cesa rafarrad to medical axaminar? Be 26. Placa of Daath (Chack only ona) To 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Daath 28d. Dascribe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Panding Invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) n 24 hours after dea ne Funerel Director oletely filled in by th 6 Could not be detarmined 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and due to the causa(s) and mannar as steled.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and mennar stated. 29a. Cartifiar Medical To the Hosp within 24 ho To the Fune completely f (Check only one) 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signad (Month, Dav. Year)

Registrar

31. Data filad (Month, Day, Year)

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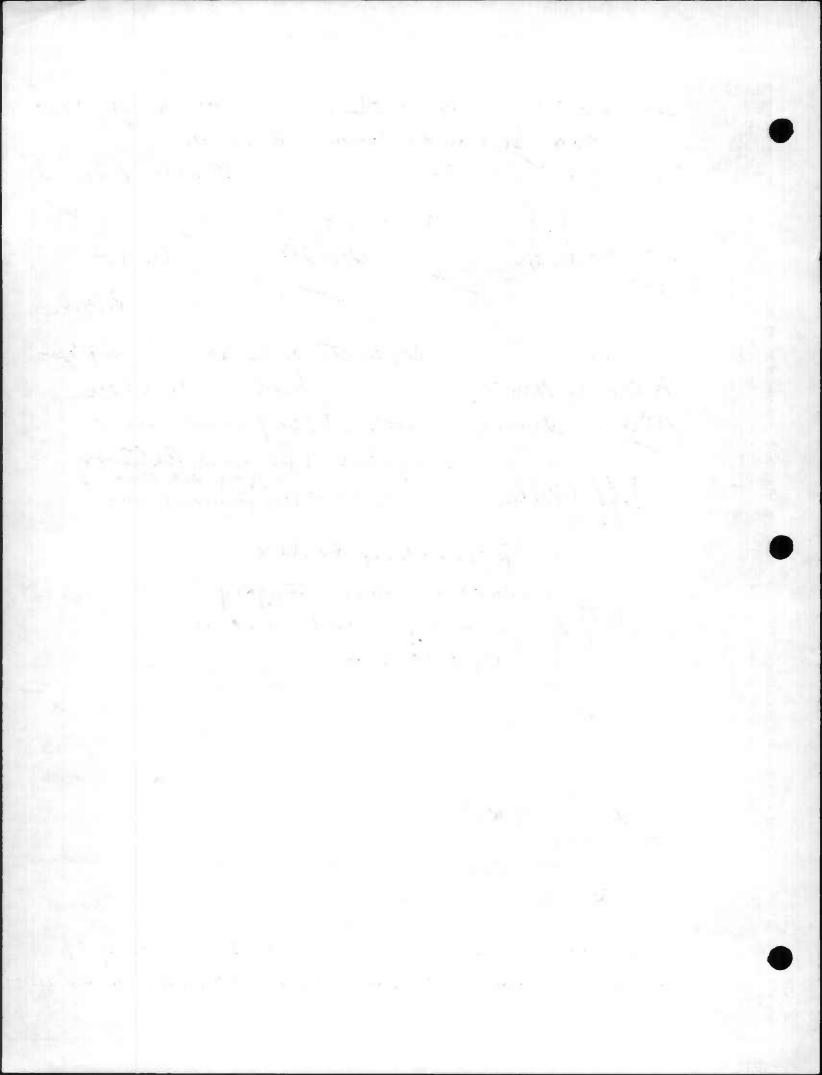
1 Hom to 32. Registrar's Signature

MD

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30. Nama and addrass of parson who complated causa of daath (Itam 23a) (Type, Print)

W Northern Pleasy, BATTIMORE, MD 21215 4000



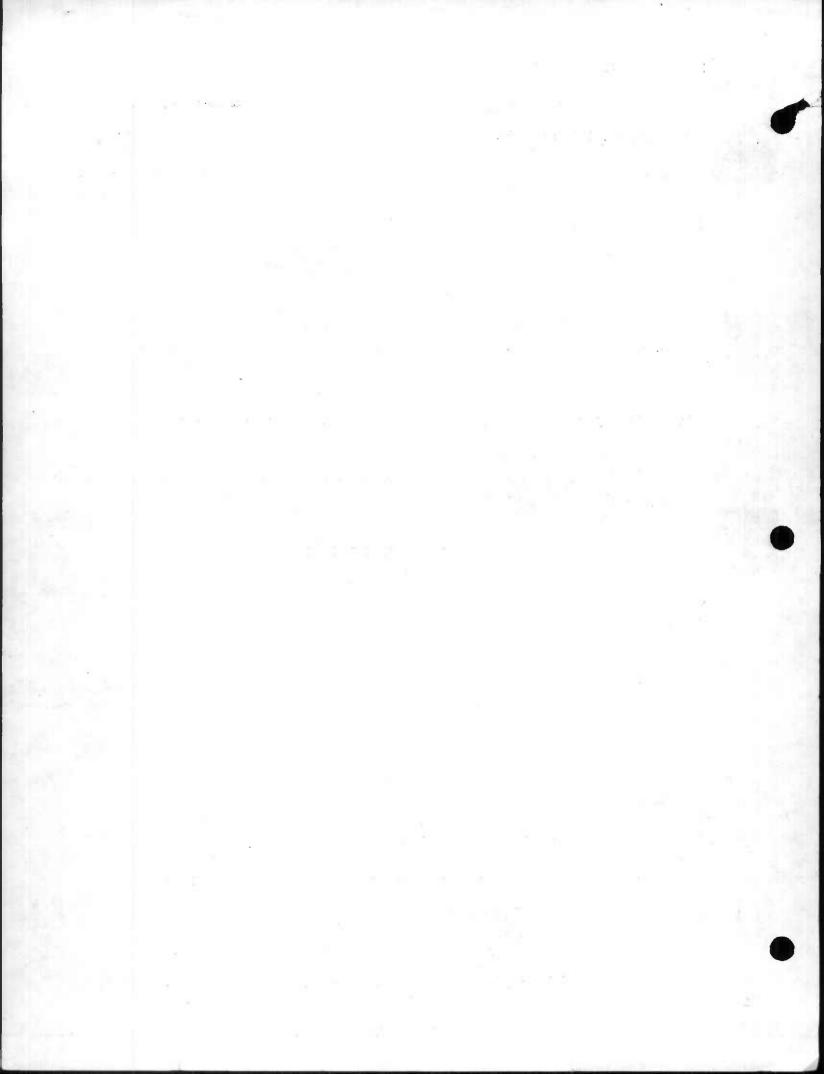
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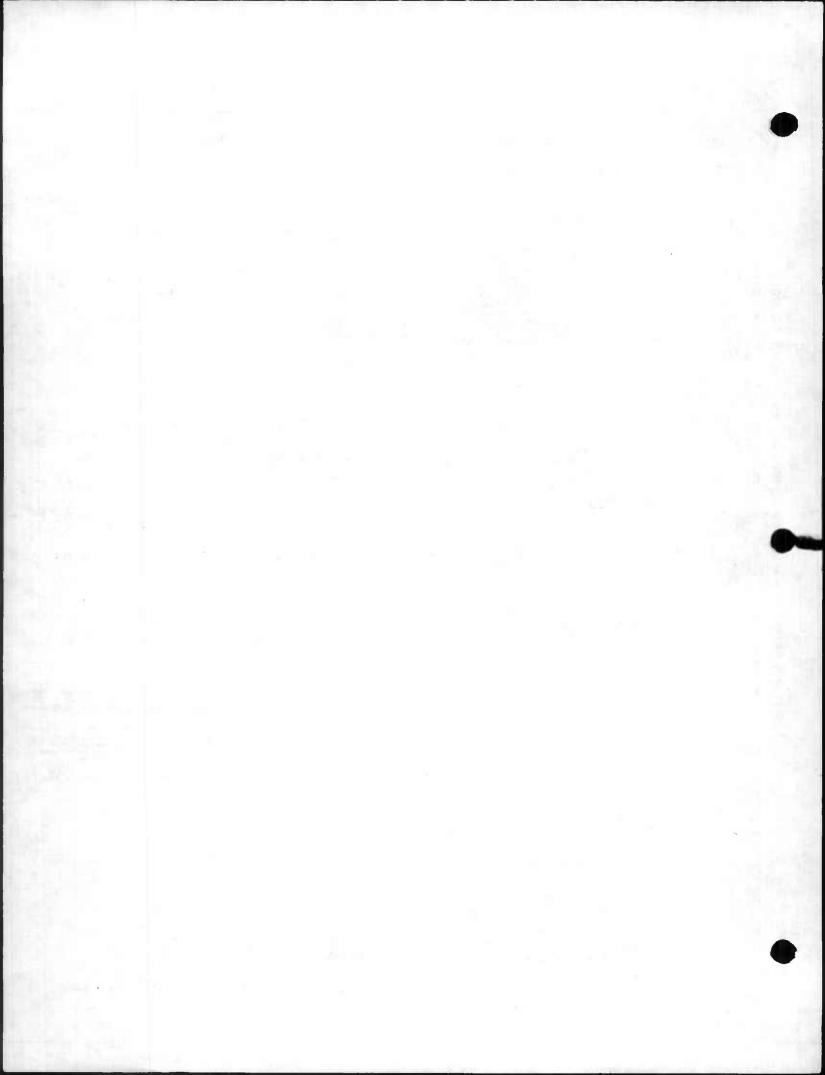
32. Registrer's Signeture

111 Penn Street, Baltimore, Maryland 21201



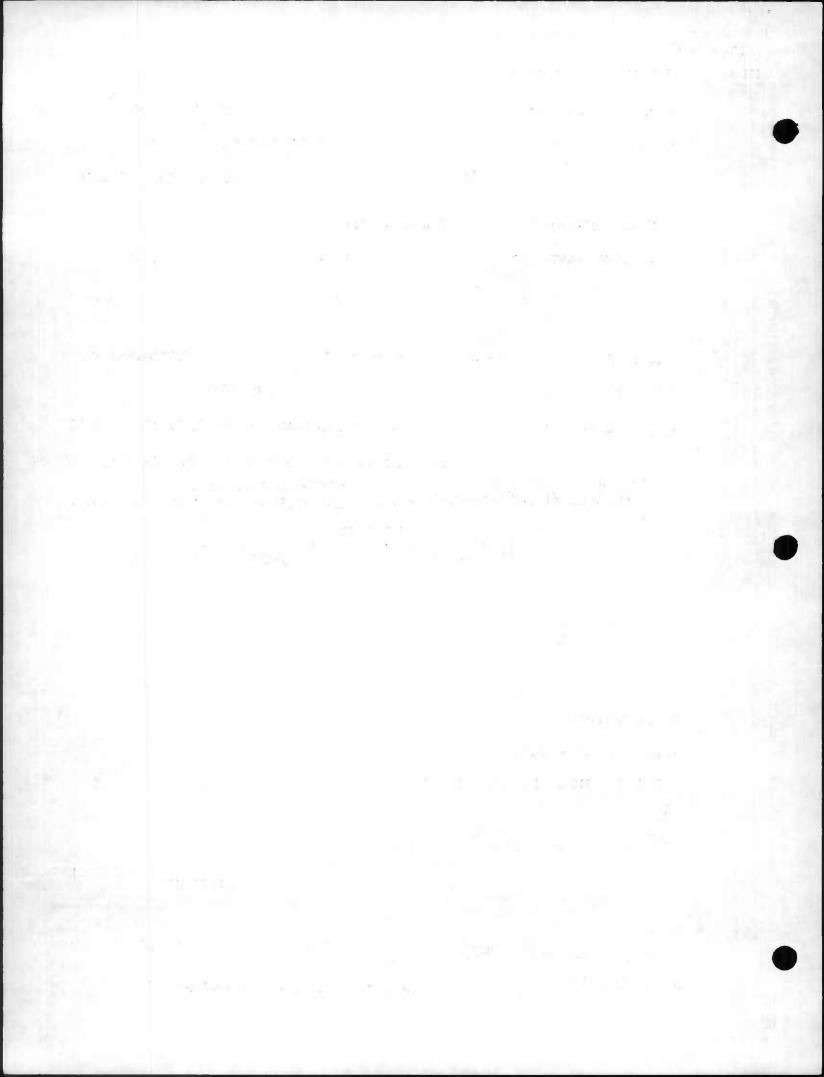
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		1. December 1. Name of	See Adioble 1 and		ryiaria		ificate of	Death	2. Date of D	Reg. No. 9		5315
Physicia /Medica		1. Decedent's Neme (F	4 P	RESGR	AVE	=5			Month Z	Day 18	Year 99	3. Time of Death
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Funeral Director		5. Sociel Security Number 214-26-148	6	7. Age	68		Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	of Birth (State or Foreign Country) 15, 1930 Maryland		
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desth with the Manyland ma 23a or 28a-f ahow mant be notified at	Funeral Director	10e. Street and Number 7736 Shar		rive			10f. Zip Code 207	94	10g. Citizen of What Country? USA			
020 urs after af', or to	Completed by Funer	11. Meritel Stetus 1 Nevar Married 3 Widowed 4	/ \	12. Was Decedent E Armed Forces? 1 Yas 2 N If Yes, Give Yeer or Detes:	If Yes, specify Cuban, Mexican, Puerto			ecity Yes or N Rican, etc.)		ce - Americ ck, White, o	etc.	
72 he		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collaga (1-4or 5+)				(Give kii life. DC	nt's Usuet Occup nd of work dona NOT use retire	during most of work d)	ing	16b. Kind of B		dustry
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Baltimore, permit. Pages 1 a Department of Hei Important: If Item any Injury or othe		21. Signature of Funar	at			Gar	0 Washi	ufman Fun ngton Blv	neral Home @ Meadowridge MP .vd., Elkridge, Md. 21075			-
Physician		23a. Part1. Enter the d shock, or haert fa	liseese, or compl ilure. List only o	icetions thet caused ne ceuse on each lin	the death.	Do not enter	the mode of dyir	ng, such es cardiac	or raspiratory	errest,		Approximeta Interval Between Onset and Death
/Medical Examiner	1	Immediata Causa (Fina disaasa or condition rasulting in daeth)	ai	Gast	POTAT Dua to (or a	estives a conseque	nal lance of):	remor	hage		1	2 days
68760, icate be executed physicient and is the burishtransit	cal Exan	b. Due to (or as e consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Leaf									1	
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17	1	30. Neme and ddress	of person who co	ompleted cause of de	eth (Item 2	3a) (Type, Pr	int)			-/	10/1	
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al', or itema 23a or 28a-f show Examiner must be notified at by Funeral Director		0a. State 10b. Count	ty		10c. C	ty, Town or Location							10		e City Limits
be notified Director		MARYLAND HOWA	ARD		E	LLICOTT C		-4							Yes 2∭ No
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To		9a. Informant's Name/Relation	-	ype, Print)		19b. Mailing Add	lress (Stree					Cify or Town	, Stete, Zip	Code)	
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		A. LEAN BEAN (Da. Method of Disposition	(FKI	END)	20b.	Place of Disposition	(Name of		- A	Date		c. Location			
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	23a. Part / Enter the disease, or complications that caused the deeth. Do not ended of dying, such as cardiac or responsible, or heart failure. List only one cause on each line.									* ** * * *	TTTIO	TOTE ME	A TO TET A N	ID 2	1220
dical niner	lr d	shook, or heart failure. Lis mmediate Cause (Finel lisease or condition esulting in death)	or compl st only o	licetions thet one cause on	tenos	th. Do not enter the DRUG INTOXI	mode of dy CATION	ring, such as ca						Approxi Intervel	
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Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#10a per FHG768 2/23/99 EW 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month FEB 18 1999 EVELYN PEARLMAN 12:35PM 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth MILFORD MANOR NURSING HOME PIKESVILLE BALTIMORE If Under 1 Year If Undar 24 Hrs. 7. Age (In yrs. last birthday) 8. Dete of Birth Month, Day Yeer NOV. 24 1920 9. Birthplece (State or Foreign 5. Social Security Number Months Deys 1□M 20 F Hours MARYLAND 78 215-10-3024 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 Yes 2 No MD BALTIMORE PIKESVILLE 10f. Zip Code 21208 10g. Cftizen of Whet Country? 10e, Street and Numbe 4204 OLD MILFORD MILL ROAD 12. Wes Decadent Ever In U,S. Armed Forcas? Wes Decedent of Hispenic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indien. 11. Marital Status Bleck, White, etc. 1 Never Merried 2 ☐ Married 1 ☐ Yes 2 ☐ No if Yes, Give X Yaar or Detas: 1 ☐ Yes 2 ☐ No Specify: SPORMITTE 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest greda completed) Coilege (1-4or 5+) Elementery/Secondery (0-12) RETAIL SALES 12 18. Mother's Neme (First, Middle, Maiden Sumeme)
LEVINE 17. Fathar's Nama (First, Middla, Last) PEARLMAN MAX 19a informent's Neme/Reletionship (Type, Pnnt)
STALET J. PEARLMAN/BROTHER 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) PIKESVILLE MD 21208 3901 SEVENMILE LANE APT. G-4 20b. Place of Disposition (Nema of 20c. Location - City or Town, Stete 20e. Method of Disposition B' NAT OF THE PROPERTY OF THE N Burial 2 ☐ Cremetion 3 ☐ Ramoval from State BALTIMORE 4 ☐ Donetion 5 ☐ Other (Specify) CEMETERY 21. Signature of Funger Service Licenses 22. Nama and Address of Fecility SOL LEVINSON & BROS. 21208 8900 REISTERSTOWN ROAD PIKESVILLE MD e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, failure. List only one cause on each line. Approximete intervel Between Onset end Deeth immediate Cause (Finel disease or condition resulting in death) Congestive heart failure 100 Due to (or as a consequence of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted evants resulting in death) Last Due to (or as e consequanca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 3 Probably 4€JUnknown 1 □ Yes 2 □ No 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28b. Time of 28d. Describe how Injury occurred

Physician/Medical Examiner Division of Vital Records, P.O. Box 68760, The law requires that the death certificate be the attanding physicis signed by the a þ Completed peen s page 2 has cartificate : After this cartifica e funeral director, p Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this cartifice Be Certification: To filled in by

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

2

Completed

7 is marked other than "natural", or frems 23s or 25s-f show trsumstic event, the Medical Examinat must be notified as

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Heelth and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or forms 23e any injury or other traumatic event, the Medical Experiment 23e any injury or other traumatic event, the Medical Experiment 23e.

Physician

Examine

/Medical

Baltimore, Maryland 21215-0020

the Marylend

with

25. Wes case referred to medical 1 Yas 2 No 27. Manner of Deeth 1 Neturei 5 Pending

2 Accident

3 Suicide

29a. Certifier

edicai

State

Registrar

completaly

within 2

4 Homicide

(Check only one)

28e. Dete of injury (Month, Dey Year) invastigation 6 Could not be determined

28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

leted cause of deeth (item 23e) (Type, Print)

28c. Injury et Work?

tractifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pieca, end due to the ceuse(s) end menner es stated.

1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29b. Signeture end title of cartifier

29c. Licanse number

2 Medical Examiner: On the besis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and pleca, and due to the cause(s) end menner stated.

29d. Date signed (Month, Day, Year)

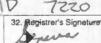
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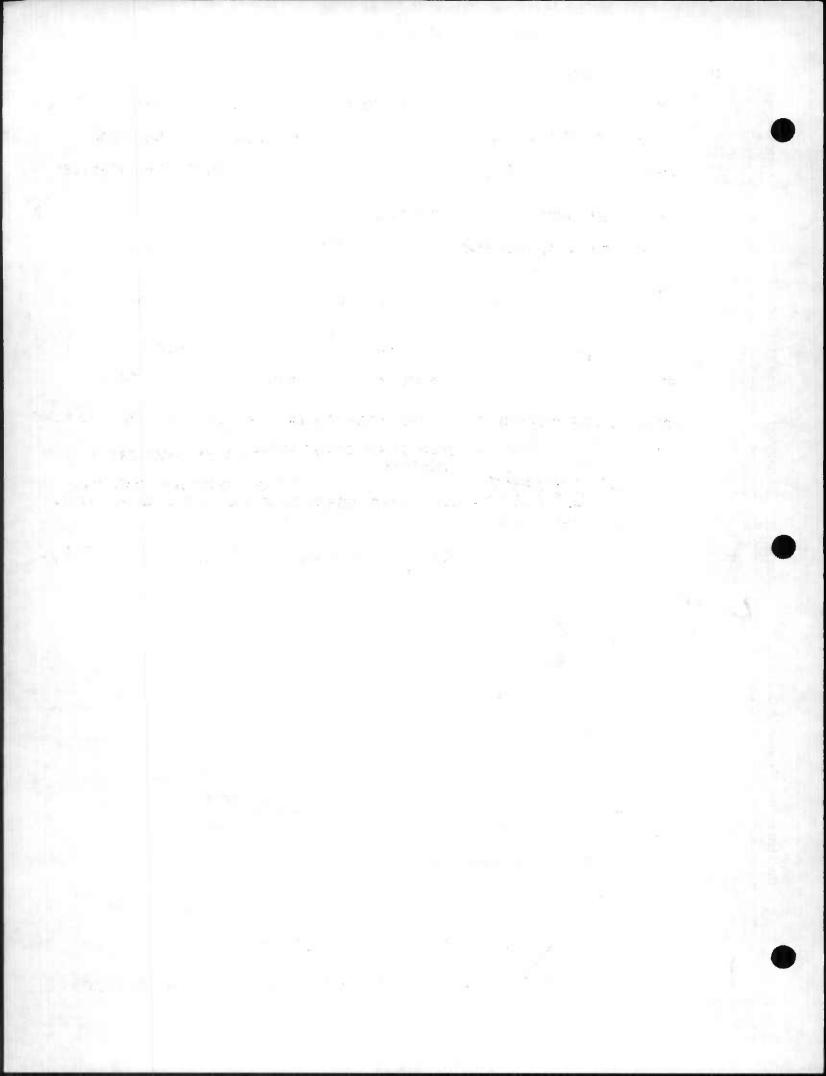
30. Neme and eddress of person who co Jef Zibel'

31. Dete filed (Month, Dey, Year) 1999 FEB 23





Park



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#8 per FHG768 2/23/99 EW 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth Dey **Physician** PICKEREL FEBRUARY 17 1999 HILDA /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RANDALLSTOWN BALTIMORE NORTHWEST HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth 9-28-17 | 9. Birthplece (State or Foreign Months | Deys | Hours | Min. | (Month Desy Year) | 7 | MARYLAND 5. Sociel Security Number 7. Age (In yrs. lest birthdey) **Funeral** 1 M 2 XF 212-12-1821 81 Yrs. Director Usuel Residence of Decedent tha Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pegas 1 and 2 should be filed within 72 hours aftar death with tha Maryla Department of Haalth and Mantal Hydiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show my injury or other traumatic event, the Medical Examinet must be notified an once. Yes 2 No Director BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21215 U.S.A. 3716 CLARINTH ROAD Funeral 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever In U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2√ No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify WHITE þ 3€Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) LENA HYATT **JACOB** SCHUSTER 0 19e. Informent's Name/Reletionship (Type, Print)
NATHAN SCHUSTER / BROTHER 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)
124 HARRY LANE APT.D OWINGS MILLS MD 21117 20b. Place of Disposition (Neme of 20c. Location - City or Town, Stete 20a. Method of Disposition ZTCHRON "ABRAHAM" NACHMAN 1 XBurial 2 ☐ Cremetion 3 ☐ Removel from State 2/19/99 BALTIMORE 4 ☐ Donetion 5 ☐ Other (Specify) CONG. CEMETERY 22. Name end Address of Fecility SOL LEVINSON & BROS. INC. 21. Signeture of Funeral Service Lic 8900 REISTERSTOWN ROAD PIKESVILLE MD 21208 ing the deese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, head failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** Immediete Ceuse (Finel diseese or condition resulting in deeth) SEPSIS /Medical Examiner THROMBOSIS Examiner RTERIAL Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest that the death cartificate be ex Physician/Medical Due to (or es e consequence of): tha Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Ohnknown DIABETES MELLITUS Division of Vital Records. by 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed hes 1 Yes 2 No 1 ☐ Yes 2 Pario cartificeta ai or Attending Physician: T s efter daath. I Director: Aftar this carifical 25. Wes case referred to medical examiner? Be 28. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 □ ER/Outpetient 3 □ DOA 28e. Dete of Injury (Month, Dey Year) funaral 27. Menner of Deeth 28d. Describe how injury occurred 28b Time of Certification: 28c. Injury et 1 DNaturel 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ HomicIde To the Hospital
within 24 hours a
To the Funeral C Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end manner stated. 29e. Certifier Medical (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year)

9

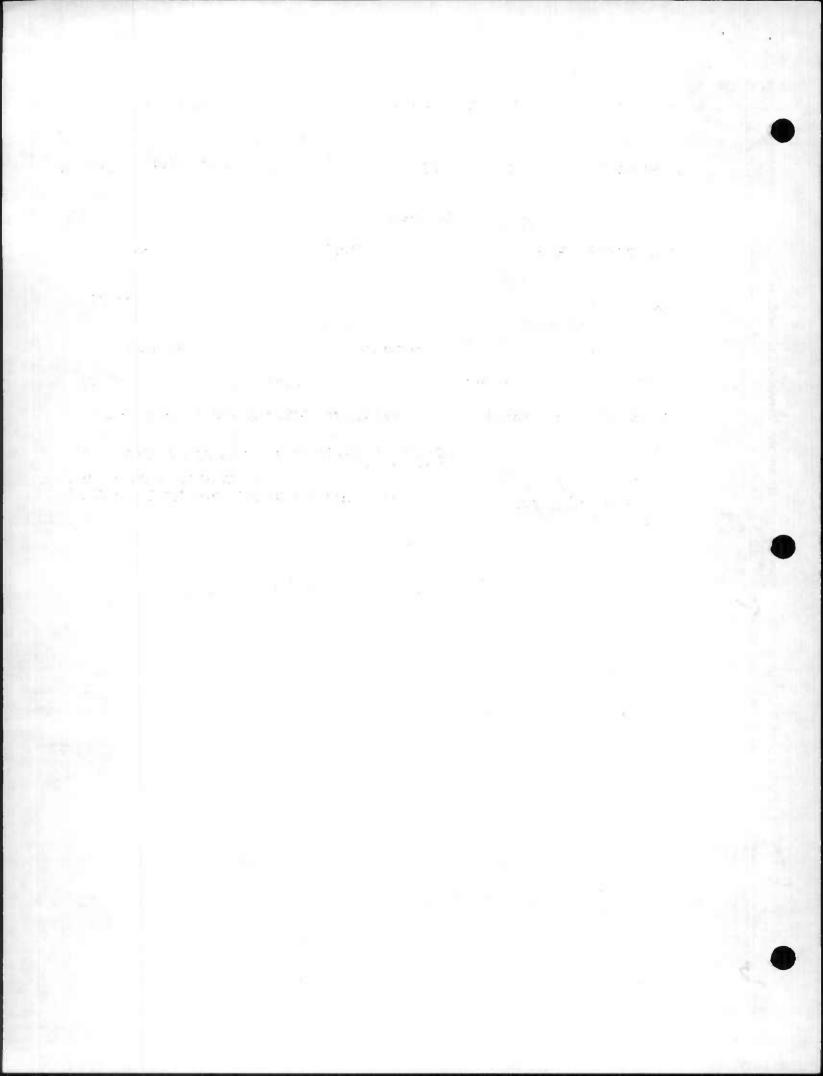
State Registrar 31. Dete filed (Month, Day, Year) FEB 2 3 1999 NHC, 32 registrar's Signature

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

C. P. A.V.I. M.P. N.H.C. R.A.I.

BALTO- MOZI133

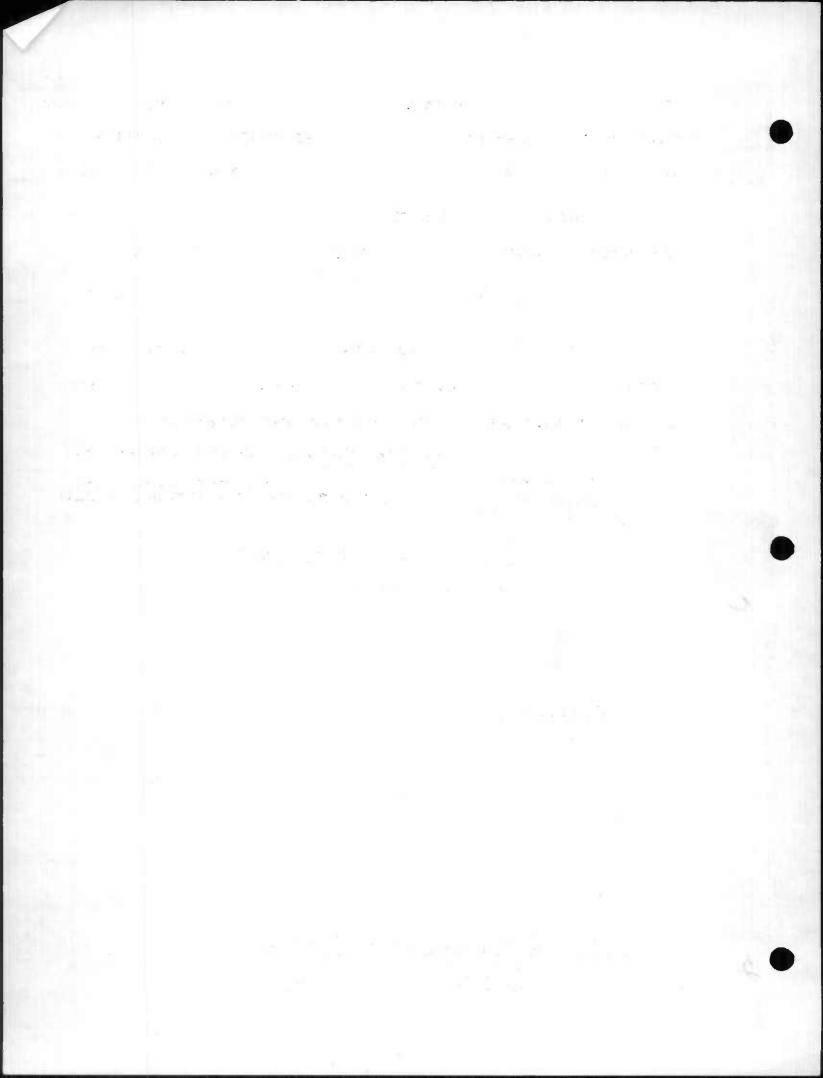
PEBRUARY 17, 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 99

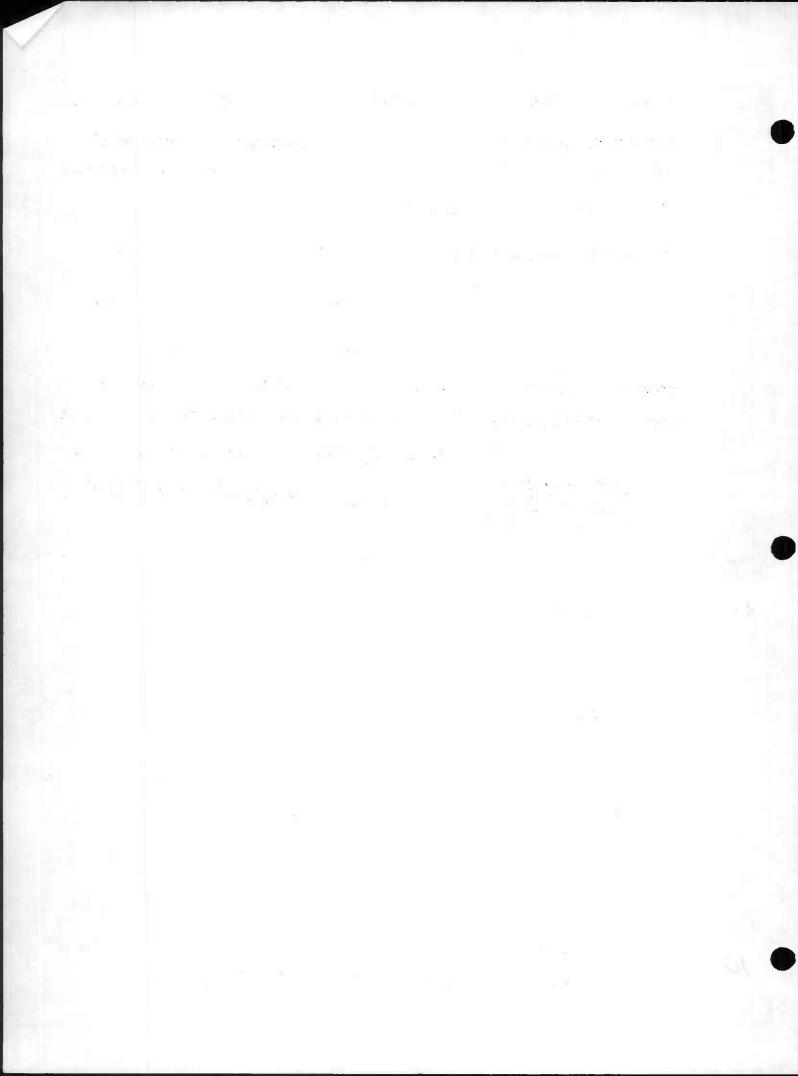
	Certifi	cate of Death	Reg. No. 9 9	05319			
Physician	Decedent's Name (First, Middle, Last) IDA PLOTKIN		2. Date of Death Month FEB. 19 1999	3. Time of Death 9:40AM			
/Medical Examiner	4a Fecility Neme (If not institution, give street end number) HURWITZ HOUSE 135 SLADE AVE.	4b. City, Town, or Loc PIKESVILI	cation of Death 4c. County				
Funeral Director		Under 1 Year If Under 24 Hrs. nths Days Hours Min.	8. Date of Birth (Month, Day Year) APR • 15 1905	9. Birthplace (State or Foreign MARYLAND			
Marylend Ind at	10a. State 10b. County 10c. City, Town or Location MD N / A BALTIMORE	n		10d. Inside City Limits 1			
th with the Ma. 23s or 28s-1 s	10e. Street and Number 6500 HOPETON AVENUE	of. Zip Code 21215	10g. Citizen of V				
be filed within 72 hours efter death with the Maryland be filed within 72 hours efter death with the Maryland other than "natural", or flems 23s or 28s-f show event, the Madical Examiner must be notified at Be Completed by Funeral Director	1 Never Married 2 Married 1 Yes VV No	Decedent of Hispanic Origin? (Spe , specify Cuban, Mexican, Puerto F res 2 No Specify:	Rican, etc.) Blac	e - American Indien, kk, White, etc. /: WHITE			
filled within 72 hours of Hygiene. Hygiene and the matural", or and, the Medical Evant Be Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (012) College (1-4or 5+) PROPRIE	Usual Occupation of work done during most of workin OT use retired) TOR	16b. Kind of Bu	store			
Se se se	17. Fether's Name (First, Middle, Last) SAMUEL GOLDBERG	18. Mother's Name REBECCA	(First, Middle, Meiden Sumer	DAVIS			
5425	DR. ALAN L. PLOTKIN /SON 3500 NOR	Idress (Street end Number or Rure THRIDGE DRIVE BA	ALTIMORE MD 21	208			
Pege nnt: if iry or	20a. Method of Disposition 1 Burlai 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) 20b. Piace of Disposition	BENEFICIAL 2,	Date 20c. Location - BALTIM	Olty or Town, State ORE MD			
permit. Depertminents Imports any inje		REISTERSTOWN RO	DL LEVINSON & BROS. INC. ROAD PIKESVILLE MD 21208 ac or respiretory arrest, Approximate Interval Between				
artificate be exampled ing physician en e as the buriel-transit	Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting in deeth) Last Level 1 Sculpt 1 Due to (or as a consequence course. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting in deeth) Last Due to (or as a consequence course of the co	ne of):	/1				
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bed bed y	Arthritis		1 Yes 275 No	3 Probably 4 Unknown 24b. Were autopsy findings available prior to			
he law e hes t age 2 s	7-1		performed?	completion of cause of death?			
ysiclan: The s certificate director, par	25. Was case referred to medical examiner?	26. Place of Deeth	(Check only one)				
ding Phys h. After this funeral di	Hospital:	28c. Injury at Work?	me 5 ☐ Residenca 6 ☐ Oth 28d. Describe how injury occur				
5 5 5 5	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Ptace of Injury - At home, farm, street, building, etc. (Specify)	,	28f. Location (Street end Numb City or Town, Stete)				
To the Hospital within 24 hours of To the Funeral completely filled	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occ and manner stated.	gation, in my opinion, deeth occurre	ed et the time, date and place,	and due to the ceuse(s)			
V To within to To my	29b. Signature and title of cartifier Willborah Mons WWO	29c. License number 031364	29d. Date stone	d (Month), Day, Year)			
State	30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print	ngs Mills, N	W 21117				

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

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Examiner Power P				PORTNEY				3. Time of Deeth 9:12pm	
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100, Edys Town of Location 10d, Inside 10d		216-03-1451 A		Months		8. Dete of Birt (Month, De AUG 3	y, Year) 1918	B. Birthplaca (State or Foreign County) VIRGINIA	
New York of Married New York Name Na	f show		10c. Cit BAI	y, Town or Location CTIMORE				10d. Inside City Limits	
The composition of the composi	at be not al Direct		E. APT. 604						
4 Donation 5 Other (Specify) 21. Signature of F instal Service Licensies 22. Name and Address of Fecility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE MD 21. Signature of F instal Service Licensies 23a. Part I. Entire the based of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximately a property of the service Licensies 23a. Part I. Entire the based of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximately list conditions, if entire leading in deeth) Sequentially list conditions, if entire leading in deeth) Sequentially list conditions, if entire leading in deeth) Sequentially list conditions, if entire leading in deeth) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25b. Did tobacco use contribute to the cause in the limited devents or resulting in the underlying cause given in Pert I. 25c. Was an endopsy performed? 25c. Was case referred to medical examiner? 1 Yes 2 No 1 Yes 2 Yes er, or items 2	1 ☐ Never Married 2 Merried	Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give	. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 1 No If Yes, specify Cuben, Mexit If Yes, specify Cuben, Mexit I □ Yes 2 1 No If Yes, Specify Cuben, Mexit I □ Yes 2 1 No I □ Yes 2 1 No I □ Yes 2 1 No			Black,	White, etc.		
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Second S	Department of Healt Important: If Item 2: any Injury or other: pnce.	1 Burial 2 □ Cremation 3 □	Removal from State BE	Placa of Disposition (National Place) of Disposition (National Place) of EMETERY	position (Neme of Dete 20c. Location - City or				
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29a Certifier 17 Certifying Physician: To the hest of my knowledge death occurred at the time date and place and due to the cause(s) and manner as stated	od in by th	datarminad	288. Place of injury - At h	ome, farm, street, factory)	ory, offica			r or Rurel Route Number,	
(Check only 2 Mydical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, end due to the cause and manner stated.	pletely fill edical	(Check only 2 Medical Exar	niner: On the basis of examina						
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer, D 47704 7/20/99	To the	29b. Signature and title of certifier	ND	2	9c. License number	4	29d. Date signed $7/7$	(Month, Dey, Yeer)	
30. Name end address of person who completed cause of death (Item 23e) (Type, Print) 4000 of all court round TRUNG PHAM T.D. Pikewiller MD	10				2000 010 0	ourt ro	اد		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Year WOODROW 1999 3:35 FEBRUARY 21 4a Fecility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE If Under 24 Hrs. 8. Date of HOPKINS OHNS MEDICAL DAYVIEW ! 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan. 29, 1917 Birthplace (State or Foreign Country) 5. Social Security Number 1 X M 2 □ F Months Days Hours Min. 82 Yrs 213-07-8836 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maruland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 108 S. Stuart Street 21221 U.S.A. 12. Was Decedent Ever in U,S. Anned Forces? 1 (△ Yas 2 □ No If Yes, Give Year or Dates: (W(t)) 13. Was Decedent of Hispenic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican indien. Black, White, atc. 1 Never Merried 2 Married 1 Yes 2 No Specify: White Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Blacksmith Steel Industry 6th Grade 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Charles Ruland Price Martha Madeline Ralu 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 108 S. Stuart St., Baltimore, MD 21221 Sandra L. McLoughlin (dghtr) 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Burial 2 Cremation 3 Removel from State Gardens of Faith Cem. 2/24/99 4 ☐ Donation 5 ☐ Othar (Spacify) Baltimore, Maryland 22. Name end Address of Fecility 21. Signeture of Funeral Service Lice Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death Immediate Cause (Final disease or condition resulting in death) ESPIRATORY FAILURE MINUTES DAYS HEMORRHAGE NTRACEREBRAL Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last Due to (or as a consequence of). TROKE Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? 3 □ Probably 4 □ Unknown 1 Yes 2 No 24b. Were autopsy findings evaileble prior to 24e. Was en eutopsy performed? YPOTENSION completion of causa of death? HRONIC OBSTRUCTIVE PULMONARY DISEASE 220No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Dete of tnjury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Deeth 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 Tyes 2 No 6 ☐ Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicten: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Division of Vital Records, P.O. Box 68760, or Attending Physician: s after death. 24 hours Hospital

Physician

/Medical

Examiner

Directo

Funeral

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Funeral

Director

8

Herns 23a

8

d 2 should be filed within 7. In and Mental Hygiene.

permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n

Physician

/Medical

Physician/Medical Examiner

by

Completed

Certification: To Be

Examiner

altimore, Maryland 21215-0020

the Medical Examiner must be

To the within 2

Registrar

29b. Signature end title of cartifier

MO

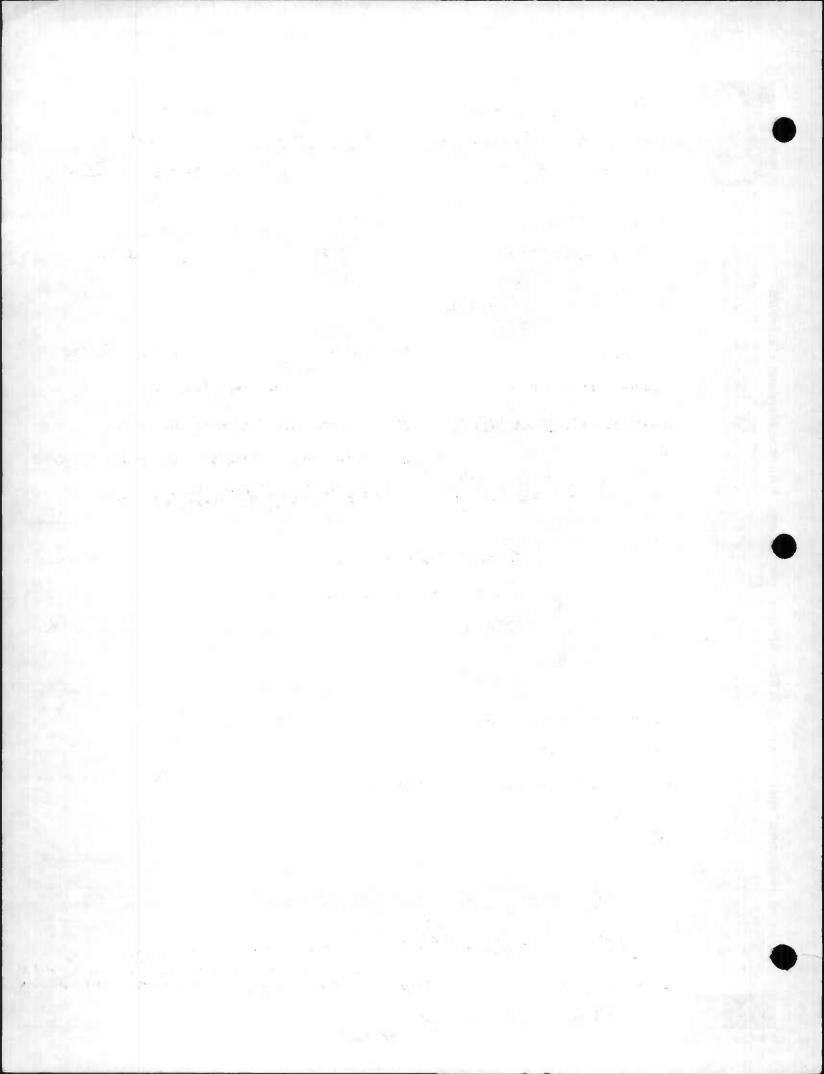
29c. License number

29d. Date signed (Month, Day, Year)

RES-000 EBRUARY

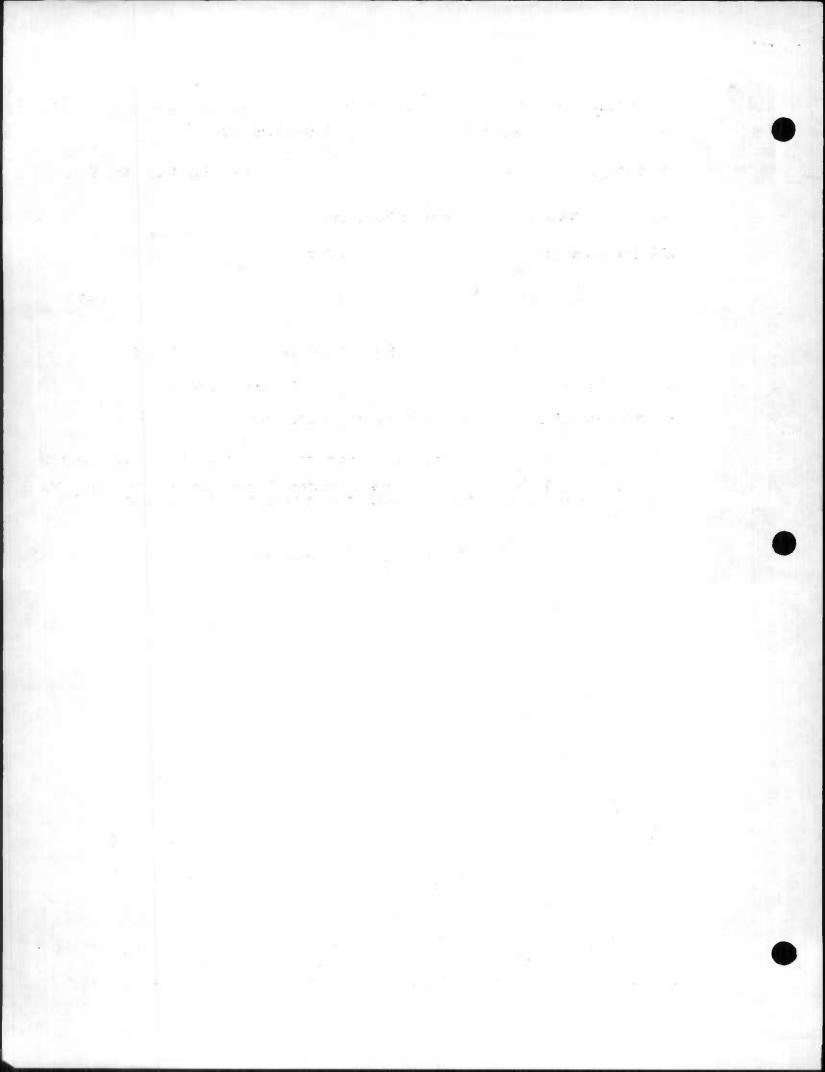
30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) JOHNS HOPKINS BAYVIEW MEDICAL CENTER MD 4940 EASTERN AVENUE, LORIN M. GRAEF BACTIMORE, MD 21224

31. Dete filed (Month, Day, Year) 32. Registrer's Signature FEB 2 3 1999



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

			Cei	rtificate of	Death		Reg. No.	00066	
	Decedent's Nama (First, Middle, Last)			,		2. Date of De	eath Day	3. Time of Death	
Physicia: /Medica		+	KOA	RKE		Februan	4 22,10	799 3:54 AM	
Examine	de Caritte Name /// and in stitution when can	et and number) HOSPITAL			4b. City, Town, o	or Location of Deat	4c. County N/A	of Death	
Funeral Director	5. Social Security Number 6. Sex 106-28-9565 1□ M Usual Residence of Decedent	2DF 7. Age (In yrs. le	ast birthday) Yrs.	If Undar 1 Year Months Days				9. Birthplaca (State or Foreign Country) New York	
/lend	10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits	
Man	NY Chemung	Town	n of E	ig Flats				1 ☐ Yes 2 No	
h with the	NY Chemung 10e. Street and Number 231 Monastery Road			10f. Zlp Code 148	71		10g. Citizen of V	What Country?	
15-0020 72 hours after death with the Maryland "naturel", or florms 23s or 28s-f show coling Examiner must be notified at	1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedant Ever in U,S Armed Forces? I ☐ Yas 2 ☑ No f Yes, Give Year or Dates:	-	Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☐ No		(Specify Yes or No erto Rican, etc.)	14. Rac Blac Specify	e - American Indian, ck, Whita, atc. White	
5-0 72 ho	15. Decedent's Education (Specify only highest grade co	on mpleted)	16a. Dece	dent's Usuel Occu kind of work done DO NOT use retire	pation during most of w	vorking	16b. Kind of Bu	usiness/Industry	
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ylan buid be Mentel arked o	Hugh B. Roarke				Gerti	rude M. S	haw		
laryla 2 should and Men is marke	19a. Informant's Name/Relationship (Type,	Print)	19b. Mailir	ng Address (Stree		Rural Routa Numb		State, Zip Code)	
	Rev. Martin Boler		231 M	lonastery	Rd., Pa	ine City,	N.Y. 14	1871	
	20a. Method of Disposition 1	oval from State	metery, cret	osition (Neme of matory or other place) OUT CEME		3/01/99		city or Town, State	
Baltimo permit. Pages Department of Important: If It any Inlury or page.	21. Signature of Politeral Service Licensee	Gueron)	ess of Facility Ufman Fu	miy Funeral Home@Meadowridge MP,] Blvd Elkridge. Md. 21075					
Physician	23a. Part1. Enter the disease, or comment shock, or heart feilure. List only one comments are comments and comments are comments.	that caused the death	. Do not ent	er the mode of dy	ng, such as cerd	lac or respiratory a	irrest,	Approximete Interval Between Onset and Death	
/Medicai Examiner	Immediate Cause (Final disease or condition resulting in deeth) a	Pulmor Due to (or	as e conse	uence of):	BOLL	2		Thous	
uted J snsit	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying	Due to fee	as a consec						
BOX 68760, eath certificate be executed ettending physician and for use as the burial-trensit	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or							
BOX 68 lath certifice steeding pt for use as t	2								
O. GO. Its death the etter hed for u	Part II. Other significant conditions contribute	iting to death but not resu	Iting in the u	nderlying cause g	iven in Part I.	23b. Dld	tobacco use co	ntribute to the cause of death?	
	£						1 Yee 2 No 3 Probabl		
COrd							s an autopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?	
The I						10	Yes 2 No	1 ☐ Yes 2 No	
	25. Was cese referred to medicel examiner? 1 Yes 2 No Hosp	ital: 1x Inpatient 2 1	-B/Outnaties	nt 3 DOA	hor	Deeth (Check only) Home 5 Res		ner (Snecity)	
0 5 5 8		8a. Date of Injury	28b. Time o			1	how Injury occur		
Attending in death.	1 Neturel 5 Pending 2 Accident investigation	Month, Day Year)	injury		Yes 2 No	NOT	Applica	ule	
DIVISION If or Attending safter death. Director: After d in by the fune	27. Manner of Death 1 Neturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 2 Homlcide	8e. Place of Injury - At hor building, etc. (Specify	, ,	1		City or To	wn, Stete)	ber or Rural Routa Number,	
	29a. Certifier 1 Cartifying Physicia (Check only 2 Madical Examiner:	n: To the best of my know On the basis of examinati	vledge, death on end/or in	h occurred et the t	ime, dete and pla opinion, death o	ace, end due to the	ceuse(s) end me date and place,	enner es stated.	
the the mplet		and menner stated.						ed (Month, Day, Year)	
5 vit	29b. Signeture end title of certifier	XZ	_		5 3 5 <u>1</u>	25			
2	30. Name and address of person who compl	eted cause of death (Item	23a) (Type.	Print) Lo	Nen	TH CAR	BLINE	7 22,1999 VD 21287	
	HENRY BOUGHER	The second secon	00516	61 - R	MUTI'M	oft 1	MARYLAN	VD 21287	
State	21 Date filed Month Day Vess!	32. Registrar's Sonat		B. 1	Louis)				



/Medical Examine sician and burial-transit physician s s the burial-Box 68760. ed by the a detached i P.O. signed by Records, certificate Division of Vital director, this After i or Attendin after death. Director: Aft

Physician

/Medical

Examiner

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Funeral

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Completed

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Certification:

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Director

7 is marked other than "natural", or itema 23a or 28a-f ahow traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiere. Important: If Item 27 is marked other than 1 any Injury or other traumatic event, the Med

Physician

the Maryland

Baltimore, Maryland 21215-0020

CORONARY 25. Was casa rafarrad to medical axaminer? 1 ☐ Yas 2 No 27. Manner of Death 1 Natural 2 Accidant 5 Panding Invastigetion 1 ☐ Yas 2 ☐ No 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida Certifying Phyeician: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Cartifiar (Check only one) 29c. License number 29b. Signature and title of certifiar 29d. Dete signed (Month, Day, Year)

State Registrar

hours (24 hours

To the To the F

31. Data filed (Month, Day, Year)

FFB 2 3 1999

BRUTMA

RE1-000

FEBRUARY 20, 1999

30. Nama and addrass of person who complated causa of death (Item 23e) (Type, Print)

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ANIEL

32. Registrar's Signatura

market may a persent the Hill Market State Strice & PROJECT AND OUT TO SELECT THE SELECT Proposition of the property of the control of the c

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 3. Time of Deeth 2. Dete of Deeth Month Richardson 1:55 PM Feberar 4c. County of Deeth 4e. Fecility Neme (If not institution, give street end number 4b. City, Town, or Location of Deet Dalfmore 5. Sociel Security Number 6. Sex If Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Dey, 7. Age (In yrs. lest birthdey) If Under 1 Year 9. Birthple 421-12-5852 Usuel Residence of Decedent 1 MM 2□ F Months Deys Yrs. 18, 1918 10b. County 10c. City, Town or Location 10d. Inside City Limits Macyland Baltimore 1 Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S. A 21218 14. Race - American Indien, Bleck, White, etc. 11. Marital Status 12. Was Decedent Ever In U.S. Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Armed Forces? 1 ☐ Yes 2 ☑ No 1 Never Merried 2 Married 1 Yes 2 No Specify: Black 3 Widowed 4 Divorcad 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Bakery ONFECTIONERY 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Richardson Willie Hattie 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Ryral Route Number, City or Town, Stete, Zip Code) 20b. Plece of Disposition (Name of cemetery, cremetory or other n Melvin Richardson SON i Kesville, Maryland 21208 Koad 20c. Location City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State Fe browne 4 ☐ Donation 5 ☐ Other (Specify) d Address of Fecility ban Gilmore Hen: 21. Signeture of Funeral Service Licenses Baltimore, Mary and 2/2/3 umone 1 5240-44 Reisterstrum Koad 23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or a many theilure. List only one ceuse on each line. Approximate Intervel Between Onset end Deeth Immediate Ceuse (Final Cerebrovascular disease disease or condition resulting in death) TENSION Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed?

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. Stete

Funeral

Director

7 is marked other than "natural", or itams 23a or 28a-f show traumatic event, tra Medical Examiner must be notified at

I Hygiena.

permit. Pages 1 and 2 should be filed.
Department of Health and Mental Hygie
Important: If Itam 27 is marked other t
any Injury or other traumatic event. In

Funeral Director

Completed by

Be

filed within 72 hours after death with the Maryland

21215-0020

altimore, Maryland

Box 68760.

P.O.

Records.

of Vital

Division

Physician/Medical Examiner þ Completed Be Medical Certification: To

bunal-transit The law requires that the death certificate be axecuted pur use as is certificate has been signed director, page 2 should be de Physician: this the funeral After or Attanding death. within 24 hours aftar deat To the Funeral Director: filled in by

To the Hospital

State Registrar

completely

29b. Signeture end title of certifier

31. Dete filed (Month, Dey, Year)

FEB 2

3

Part II. Other eignificent conditions contributing to death but not resulting In the underlying cause given in Pert I. 25. Was case referred to medical 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 27. Menger of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation Naturel 2 Accident 1 Yes 2 - No 6 ☐ Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 \ Homicide Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of exemination end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the cause(s) end manner stated. (Check only one)

29c. License number

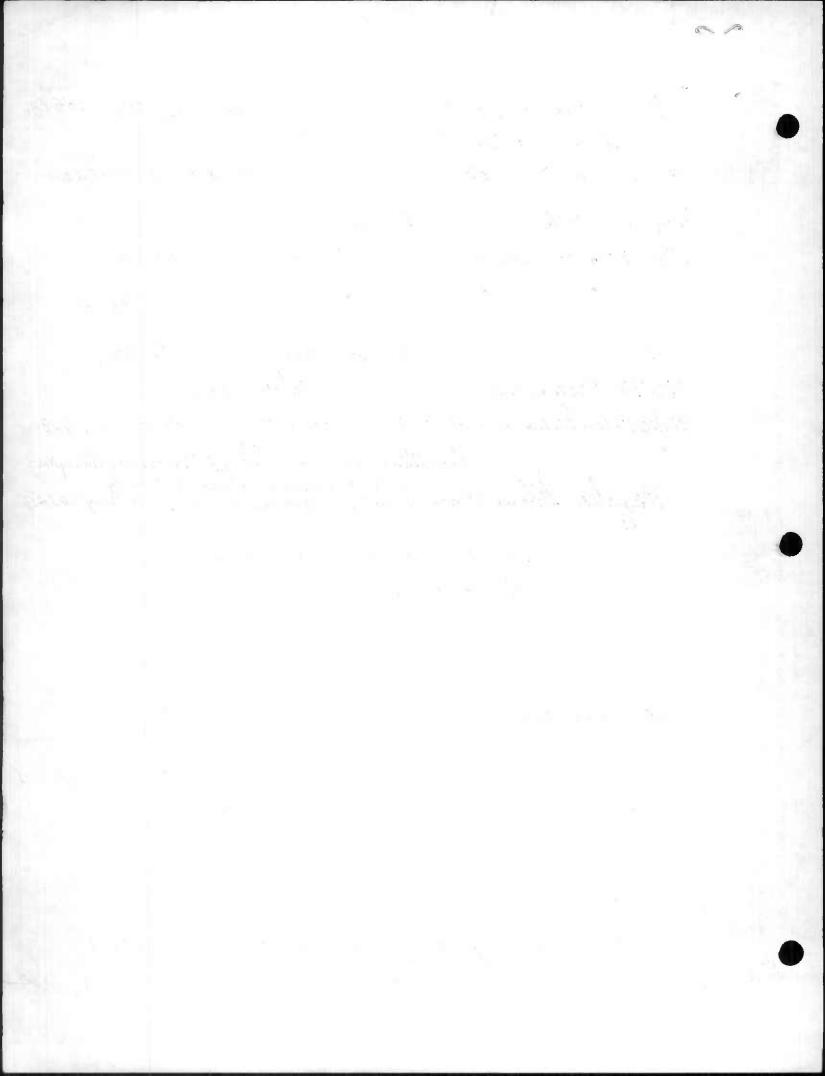
29d. Date signed (Month, Dey, Year)

deeth (Item 23e) (Type, Print) 30. Name end eddress of person who completed cause

Kn

2323 Orleans 32. Registrar's Signature

St., Baltimore, MD 21224



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 930 AM ROSENBERG Year EVA **Physician** 17 /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner General Baltimore Hospital 8. Date of Birth
JULY 29 Years 05 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Deys Months Hours 1□M 20 F 93 Yrs. MARYLAND Director Usual Residence of Decedent the Marylend 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County me 23a or 28a-f ehow BALTIMORE Yes 2 No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? death with 21210 U.S.A. 116 W. UNIVERSITY PKWY APT. 1032 Funeral 12. Was Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 7 is marked other than "naturel, or items traumatic event, the Medical Examiner in 14. Raca - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1X Never Married 2 Merrled Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE p 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) Hygiena. College (1-4or 5+) Elementary/Secondary (0-12) RELIABLE STORES CORP KEY PUNCH OPERATOR 18. Mother's Neme (First, Middle, Maiden Sumame) t7. Father's Neme (First, Middle, Last) Be 1 end 2 should be Health and Mental ROSENBERG MOLLIE LOUIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zlp Code) 427 COLONIAL RIDGE LANE ARNOLD MD 21012 19a. Informent's Name/Reletionship (Type, Print) Department of Health as important if from 27 is any injury or other traus JACK KAUFMAN/NEPHEW Baltimore, 20b. Placa of Disposition (Name of 20a. Method of Disposition

f⊞Burial 2 ☐ Cremetion 3 ☐ Removal from State Date 20c. Location - City or Town, State Pages nent et P HAR ZION TIFERETH ISRAEL 2/19/99 BALTIMORE 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 21. Signature of Funeral Service Lice 8900 REISTERSTOWN ROAD PIKESVILLE MD Approximate Interval Between Onset end Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feilure. List only one cause on each line. **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Cardiac Examiner Examiner in farction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last death certificate be ax ardio myo pathy Box 68760. Physician/Medical Due to (or es e consequenca of) the l as use a P.O. | 23b. Did tobecco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed t Division of Vital Records, b 24b. Were autopsy findings evailable prior to 24a. Wes an eutopsy performed? Completed completion of cause of death? has page 2 1□ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2 No To 1 Inpatient 2 □ ER/Outpatient 3 □ DOA After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of Certification: al or Attending P s after death. 5 Pending investigation 1 Natural 1 Tyes 2 □ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital o within 24 hours aft To the Funerel DI 29e. Certifier 11 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner es stated. edicai completaly (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature end title of cartifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Maryland

32. Registrar's Signature

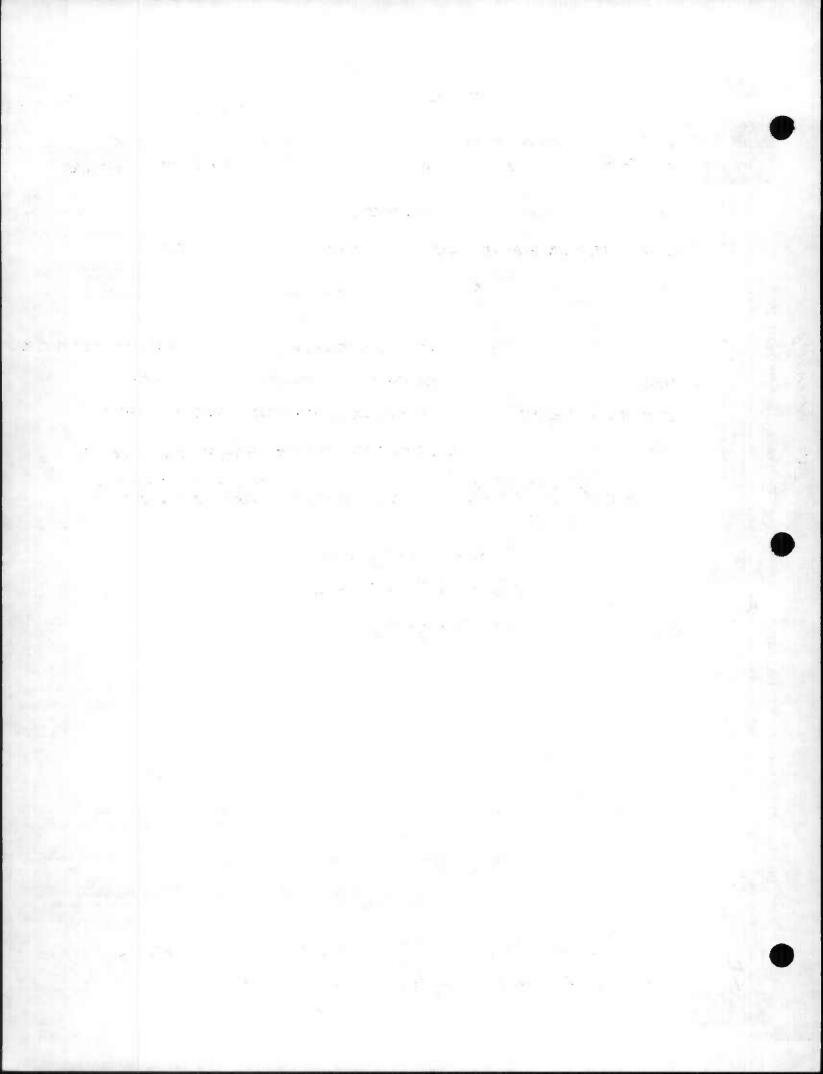
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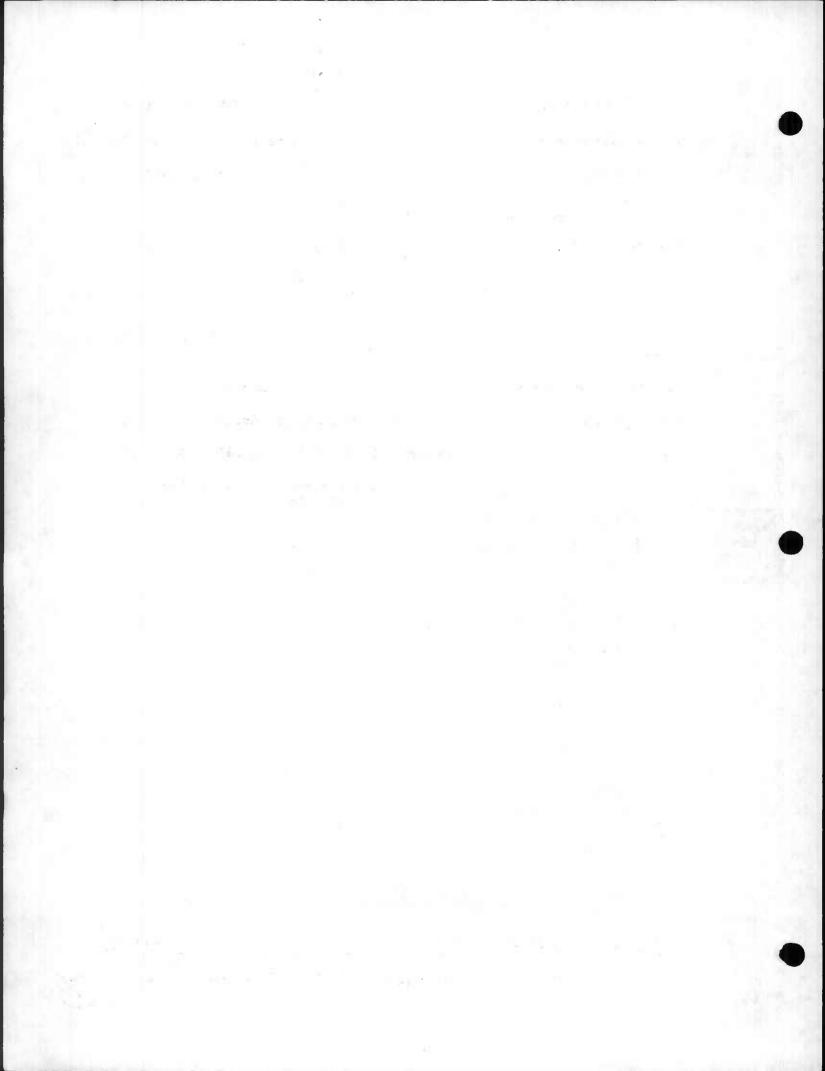
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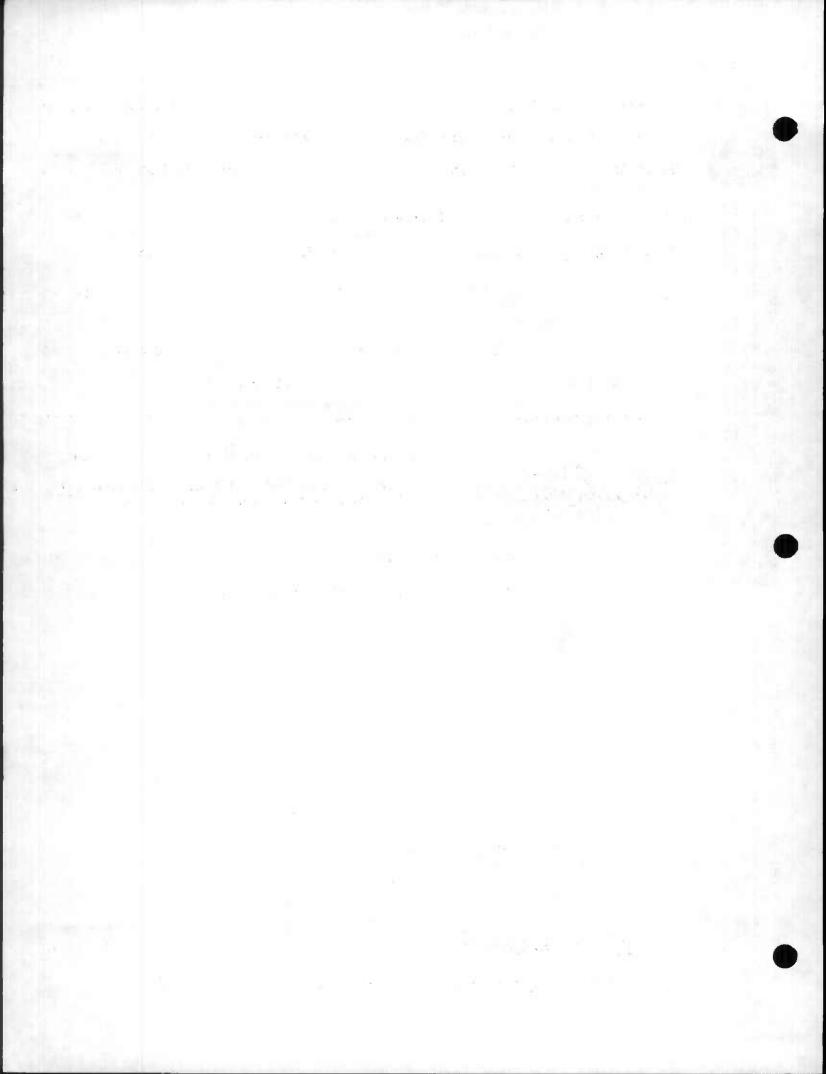
State of Maryland / Department of Health and Mental Hygiene

		Decedent's Name (First, Middle, La	st)	G19 1	Certificat	e or	Death	2 Date of Day	Reg. No.	- 0	3. Time of Deat
Physici /Medic		Nola Harris Ro	ор					Month Feb	13 ^{Dey} 19	999	2:30AM
Examin		4e. Fecility Neme (If not institution, giv	e street end number)				4b. City, Town, or I			of Deeth	
		Genesis Elder Ca	re				Severna	Park	Anne	Aru	ndel
uneral irector		5. Sociel Security Number 6. S 225-05-4054	ex 7. Ag	e (In yrs. last bir 80	thday) If Under Yrs. Months	1 Year Deys		8. Dete of Birth (Month, De)	7, Year) 25 1918	9. Birthpl Count	ece (State or Forday)
		Usual Residence of Decadent						Tidicii	23 1710	V 11.5	IIIIa
H show	tor	MD 10b. County Anne A	rundel	10c. City, Tow Sev	n or Location erna Par	k				10	od. inside City Lin 1 ☐ Yes 21☐
23a or 28a ast be not	Funeral Director	10e. Street end Number 790 Blenheim Ct.			10f. Zlp	Code 211	46		10g. Citizen of W		ry?
Important: If the 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 Married 3 Nover Married 4 Divorced	12. Wes Decedent I Armed Forces? 1 Yes 2 N I If Yes, Give Yeer or Dates:		13. Was Deced		Hispenic Orlgin? (Sean, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race Black Specify:	- America k, White, e	
than "natur	Completed	15. Decedent's Ec (Specify only highest gre Elementery/Secondary (0-12)	lucation de completed) College (1-4or 5			k done e retire	petion during most of wor d)	king	16b. Kind of Bu Fairfa		ustry Schools
ther than		17. Fether's Name (First, Middle, Last)			Cashi	er	18. Mother's Nan	ne (First, Middle,	Maiden Sumem	9)	
o peo	To Be	Claude Edison H	arris					Ada Mole		~/	
am 27 is marked o	-	19a. Informent's Neme/Reletionship (19b	. Mailing Address	(Street	and Number or Ru			Stete. Zip	Code)
27 ls		Ruth A Nielson					nada St.			2220	
Important: If Itam 27 any injury or other tr once.		20e. Method of Disposition 1 □ Burial 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Specify	Removel from State	20b. Plece of cemeter Mt C	Disposition (Namery, crematory or of Omfort C	ne of ther pla eme	ce) tery	Date 2/16/99	Alex.		vn, Stete
importa any inj once.		21. Signature of Funeral Service Licen	everly				ess of Fecility -Wheatley W Braddo			A	
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2 should	Completed to							24a. Wes e perfor	en eutopsy med?	com	re eutopsy findin ileble prior to apletion of cause eeth?
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s certificata director, pag	Be	25. Wes case referred to medical examiner?	Magnital.			100		th (Check only or			
this did	T0	1 Yes 2 No	Hospital: 1 Inpatier 28e. Date of Injur			A		ome 5 Resid)
Director: After d in by the funer	Certification:	1 Meturel 5 Pending Investigation 3 Sulcide 4 Homicide 5 Pending Investigation 6 Could not be determined	(Month, Day	Yeer) Ir	ime of a 21 njury M		yat rk? Yes 2□No	28d. Describe h 28f. Location (S City or Tow	treet and Numbe		Route Number,
	edical Cer	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Example 1	reician: To the best o	f my knowledge, exemination and	, deeth occurred e	t the tie	me, date end piece	end due to the c	euse(s) end mer late end placa, e	nner es ste	eted. the ceuse(s)
To the comple	Med	29b. Signeture end title of cartifier	end manner ste	mb	290	Licens	se number	2	9d. Date signed	(Month, D	lav. Year)
1/	-			ath (It-m and)	Tuna Palan	0	46810 75 Rite	7	413	17	
		30. Neme end eddress of person who	completed cause of de	างเก (แยก 230) (Mpe, Print)	-	0 .	a (1 A	1 . /	4	



State of Maryland / Department of Health and Mental Hy
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	Item#	LOd	,20b perFHG768 2/23/		arylan		rtificate of	f Death		Reg. No. 9 9	05327	
	Physicia		1. Decedent's Name (First, Middle,		-	713	-114		2. Dete of Dee		3. Time of De	eth
	/Medica	ıl .	Marie Linda						Februar	y 20, 19		
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	Funeral Director		214-20-8661	. Sex 7. Ag 1 M 2	ge (In yrs. k	est birthday) Yrs.	If Under 1 Year Months Dey		8. Dete of Birth (Month, Day Oct. 1	Year) 1920 T	Birthplece (State or Fo Country) Vest Virgin	oreign i1a
	and	1	Usuel Residence of Decedent 10e. State 10b. County		10c. City	, Town or Lo	ocation				10d. Inside City L	imits
	Many Fig.	ğ	faryland Howard		E	lkridg	ge				17 Yes 2	Ŋ No
	h with the	al Directo	10e. Street and Number 7236 Montgomery	Road Apt	. 1 C		10f. Zip Code	1075		10g. Citizen of Wh	et Country?	
21215-0020	urs a	by Funeral	11. Maritel Stetus 1 ☐ Never Married 2 ☐ Married 3X Widowed 4 ☐ Divorced	12. Wes Decedent Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Detes:			Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ N	Hispenic Origin? (Sluben, Mexican, Puerto o Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Rece- Bleck, Specify:	American Indian, White, etc. White	
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	be filed tal Hygie d other event,		17. Fether's Name (First, Middle, La	ist)		out	711101	18. Mother's Nan	ne (First, Middle,	Maiden Sumeme)	. L y	
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Baltimore,	Page nent o int: If I		20a. Method of Disposition 1 ☐ Buriai 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			dowrid	osition (Neme of metory or other p lge Mem.	Park (Dete 23 2/ 22 /99	20c. Location - Ci		
Bal	Depart Depart Import any inj		21. Signatura of Funeral Service	13		Ga	2. Name end Add ary L. Ka 250 Wash:	ress of Fecility aufman F. F ington Blv	I. @ Mea	dowridge ridge, N	Mem. Park,	Inc
	Physician	7	234 Port1. Enter the disease, or co hock, or heart feilure. List or	omplications that cause aly one ceuse on each I	d the death ine.	. Do not en	ter the mode of d	ying, such as cardiac	or respiratory ar	rest,	Approximate Intervel Betwee Onset end Dee	
1	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	e. Bronc							Two day	s.
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,00	ificate be executed g physician and as the bunal-transit	Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	b. CITON		es e conse		monary Dis	sease		lears.	
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of Vital Records,	The law requires that the death center has been signed by the attending page 2 should be detached for use	Completed							24e. Wes perfo	en eutopsy med?	24b. Were eutopsy find eveileble prior to completion of caus of deeth?	
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Division	Attan r deat ctor: by the	Ica	3 ☐ Suicide 6 ☐ Could no	N/A.	jury - At ho	N/A me, farm, st	reet, factory, offic		28f. Location (Denne de mart Allenda e	or Rural Route Number	r,
Ö	s aftar	Cermication:	4 Homicide	building, e	ic. (Specify	N/A			City or Tov	orreet end Number vn, State) N/A •		
		edical		Physicism: To the best sminer: On the basis of and manner st	f exemineti							
	withi Toth	M	29b. Signeture end title of certifier - B	Valland	4			30469		29d. Date signed (Month, Dey, Year) 22, 1999.	
	8		30. Name end eddress of person what N B VELLANKI, 90					Ellicott C	ity, MD2	1042.		
	State Registra		31. Date filed (Month, Day, Year)	32. Regist	rar's Signat	ure	B. 1	backs				
			1	. 0 . 4 - 4 .			//					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 Day 20 Evelyn 4a Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Deeth Bon Secours Hospital Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 1□M 2□F Months Days Yrs. 200-16-4190 75 MAR. 21, 1923 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 □ No N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 27 S. Calhoun St. 21223 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 14. Rece - American Indien, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Biack, White, etc. 1 ☑ Never Merried 2 ☐ Merried 1 ☐ Yes 2 No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 9 Machine Operator Factory 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Phillipa Chuff Bartholomew Spano 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Michael Holmes - friend 2015 Ramsay St., Balto., Md. 20b. Place of Disposition (Name of cametery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 2/27/99 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Carmel Cemetery Dunmore, Pa. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Servica Licenses Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 23a. Part1. Enter the disease, or complications that outsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. IN12 ARCTION Immediate Ceuse (Final disease or condition resulting in death) MYOCARDINL 14R1 ANTERY DISCLASE CURUNARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 1 No 1 ☐ Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1- Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how Injury occurred

Physician/Medical Examiner The law requires that the death certificate be axecuted attending physicien Division of Vital Records, P.O. Box 68760, the signed by t by should Completed been s page 2 has certificate Physician: Be 2 After this funarai Certification: or Attending s after dee. filled in To the Hospital within 24 hours a To the Funeral E edical

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

þ

Completed

7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Modical Examinat must be notified as

permit. Pages 1 end 2 should be filed within 72 hours after death 1 Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s eny Injury or other treumstic event the man

eny le

Physician

/Medical

Examiner

the Maryland

with 1

25. Was case referred to medical examiner? 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 1- Natural 5 Pending 1 Yes 2 No investigation 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifie

Critifying Phyeicten: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

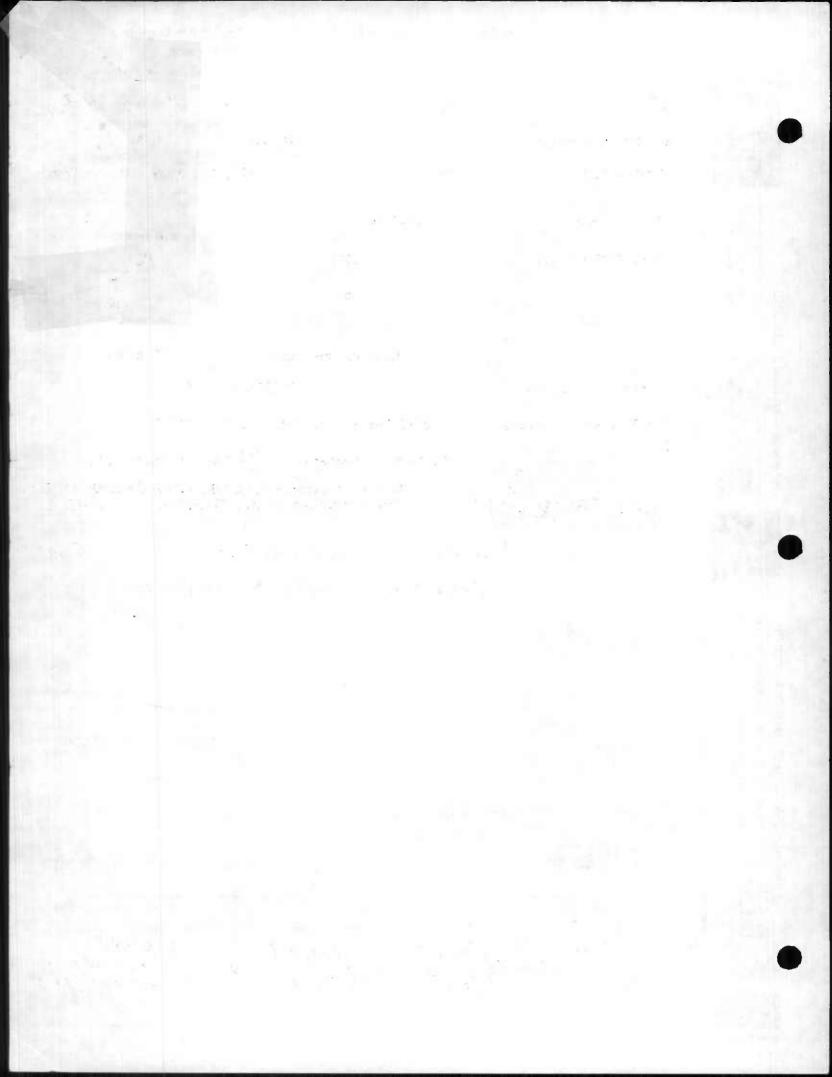
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner state. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number

30. Name and address of person who completed cluse of death (Item 23a) (Type, Print)

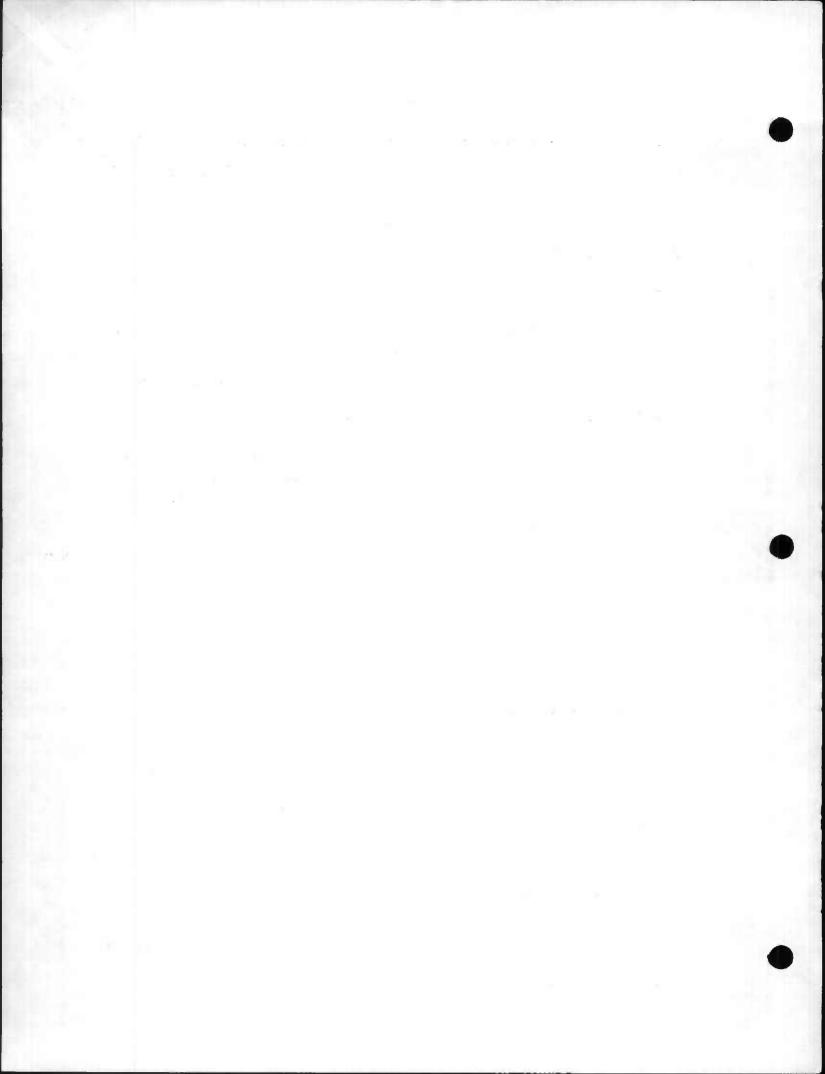
2-21-59 BACOUMON TO 2124 201

32. Registrar's Signature

State Registrar



	Decedent's Nan	ne (First, Middle, Las	st)		301		of Death	2. Date of I	Reg. No.	3	. Time of Death
ysician Medical	Dougont o Han	Ma		y S	mith			FEB.	20, 19		11:00am
	4a Facility Name	(If not institution, give	e street end numbe	r)			4b. City, Tow	m, or Location of De	ath 4c. Count	ty of Death	
		ick Vill						nsville	Bal	ltimor	
eral ctor	5. Social Security 218-03-	2024	ex	85	est birthday) Yrs.	If Under 1	Year If Under 2 Days Hours	Min. 8. Date of Month,	Birth Dey, Year) 1913	9. Birthplace Country) Mary	(Stete or Foreign 1and
or stat	Usual Residenca (10a. State	10b. County		10c. City	, Town or Loc	eation					Inside City Limits
rector	MD	Baltime	ore		Arbu	tus					1□ Yes 2□ No
olre e	10e. Street and Nu				1	10f. Zip C			10g. Citizen of	What Country?	
<u>a</u>	920 Cal	well Ro	ad			2	21229		US	A	
Completed by Funeral Director	Α	rried 2 Married	12. Was Decader Armed Forces 1 Yes 2 If Yes, Give Yeer or Dates	No.		/as Deceder Yes, specify ☐ Yes 2		in? (Specify Yes or Puerto Rican, etc.)	No- 14. Ra Bli Speci	aca - American ack, White, etc. ify: Whit	
B	/0	15. Decedent's Ed	lucation		16a. Decad	ent's Usual (Occupation	of working	16b. Kind of I	Business/Indust	ry
ple	Elementary/Sec		College (1-40)	r 5+)	life. D	O NOT use	done during most retired)	or working	Umbr		
00	6				Sea	mstre				acturi	ng
Be		(First, Middle, Last)					18. Mother	's Name (First, Midd			
10		eorge Sm							e Warf		
		Name/Relationship (920	Calwe	ell Rd.	Arbutu		n, Stete, Zip Co 21229	de)
		sposition Cremation 3 5 Other (Specify			laca of Dispos emetery, crem W Cat			tery2/23/		imore,	
any injury once.	21. Signature of F	funeral Servica Licer	1° Doma	ld				Home, P. d. Baltim		21228	
	23a. Part1. Enter shock, or he	the disease, or com art feilure. List only	3.LQ plications that caus one cause on each	ed the death line.						Ar	pproximete terval Between aset and Deeth
cian lical	Immediate Ceuse disease or conditi	ion			805					1	24 45
iner 💆	resulting in death		α	Due to (or	es a conseq	uence of):					
al Examiner	Sequentially list of any, leading to it cause. Enter Und Ceuse (Disease of that initiated even	onditions, immediate derlying	b	Due to (or	r as a consequ	uence of):					
o po	that initiated even resulting in death)	ts Last	d.	Due to (or	es e consequ	ienca of):					
Jan			U								
Physician/M	Part II. Other algn	Ificant conditiona c	ontributing to death	but not resu	ılting in the un	derlying cau	se given in Part I.		id tobacco uae c		
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2 should								24a. W	fes an autopsy erformed?	availa	autopsy findings ble prior to letion of cause lth?
rector, page								1	☐ Yes 2 No	1□Y	es 2□ No
Be C	25. Was case refe exeminer?	erred to medical						of Deeth (Check on	ly one)		
를 2	1 ☐ Yes 2 ☐		Hospital: 1 ☐ Inpa		ER/Outpatien		1	rsing Home 5□R			
funera tion:	27. Manner of Dea 1 Maturel 2 ☐ Accident	5 Pending Investigation		ijury Dey Year)	28b. Time of Injury	M 280	c. Injury et Work? 1 \(\text{Yes} \) 2 \(\text{N} \)		be how injury occ	urred	
Certification:	3 Suicide 4 Homicide	6 Could not be determined	289. Placa of I	njury - At ho etc. <i>(Specif</i> y	me, farm, stre	et, factory,	office	28f. Locatio City or	n (Street end Nun Town, State)	mber or Rurel R	oute Number,
	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exam	ysician: To the bes niner: On the basis and manner	of examinet	wledge, death ion end/or inv	occurred at estigation, in	the time, date and my opinion, deat	plece, end due to the tine	he cause(s) and r ne, date and place	manner es stete a, and due to th	ed. e ceuse(s)
dicai						29c. I	License number		29d. Date sign	ned (Month, De	y, Year)
Medical	29b. Signeture an	d title of certifier									
	•		nath	I do sale (to	00a) (T (50164	f 36 L	21	22/9.	7



BARBARA A. SEIGLE	
Division of Vital Records, P.O. Box 68760,	Baltimore, Maryland
The Hospital or Attending Physician: The law requires that the death certificate be executed to the control of	permit. Pages 1 and 2 should be fill Department of Health and Mental H

	Decedent's N	lama (First, Middle, Las	t)		11111			2. Date of D Month	eath Day	Yea		ima of Death	
ician	BARB	ARA A. SEIG	GLE							16 199		00 AM	
dical niner		ne (If not institution, giva					4b. City, Town, or I			County of De			
	ST. AG	NES HOSPITA	AL				BALTIMO	ORE		N/A			
al	5. Social Securi			n yrs. last birthd	lay) If Unda Months	r 1 Year Days	If Undar 24 Hrs. Hours Min.	8. Date of B	irth	9. E		State or Foreign	1
or	213-42 Usuel Residence	-2657	□M 2♥ F 56	Yrs	S	Dayo		DEC 18			RYLAN	ND	
	10a. Stata	10b. County	10	c. City, Town or	r Location				1-11		10d. in	side City Limits	
tor	MARYLAN	D N/A		BALTIMO	ORE						12	Yas 2 No	
Director	10e. Street and	Number			10f. Zi	ip Code			10g. Citiz	zen of What	Country?		
le l	2753 W	EGWORTH LAN	VE			2123				S.A.			
Funeral	11. Marital State		12. Was Decedent Eval Armed Forces?	r in U,S. 1	 Was Dece If Yas, spe 	edent of F ecify Cub	lispanic Origin? (S an, Mexican, Puert	pecify Yes or N o Rican, etc.)	10- 1	14. Race - Ar Black, W		Jian,	
by F		Marriad 2 Married ed 4 □ Divorced	1 ☐ Yes 2 ▼ No If Yas, Give Year or Dates:		1 🗆 Yes	2 1 No	Specify:			Specify:	WHITE		
Pe		15. Decedent's Ed	ucation	16a. De	ecedent's Usu	ual Occup	pation		16b. Kin	nd of Busines	ss/Industry		
Completed		Specify only highest gree Secondary (0-12)	de completed) College (1-4or 5+)	(G	ive kind of we fe. DO NOT u	ork done usa retire	during most of word)	rking					
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Be	17. Father's Na	me (First, Middla, Last)					18. Mother's Ner	ne (First, Middl	e, Maiden S	Sumeme)			
10		M. WEEMS						MARSHAI					
		's Name/Reletionship (7					and Number or Ru		ber, City or	r Town, Stete	e, Zip Code)	
	MADELI 20a. Method of	NE E. PARK	(DAUGHTER)	P. C	BOX	506	- OCEAN	CITY,	MARYI	LAND cation - City	21843	tate	_
	1 X Burial	2 Cremation 3 🗆	Removal from State	20b. Place of Di cemetery,									
		on 5 Other (Specify		GLEN HA			AL PARK	2/20/99	GLE	EN BUR	NIE,	MD	-
	21. Signature C	C Service Liebni					JNERAL HO	ME, INC	3.				
	23a Parti En	tor the disease or some			4107 V	JILKE	ENS AVENU	E-DAT TO	MODE	MARY	TAND	21229	
. 10	238. Falt I. Cit		digations that caused the	death Do not	ontor the mo	do of dul	on euch se cardia	C-DALII	arrest,	,	Anni	oximate	
	shock, or	heart failure. List only of	ollcations that caused the one causa on each lina.	death. Do not	enter tha mo	ode of dyl	ng, such as cardia	or raspiratory	arrest,	, 111111	Appr	roximate val Between et and Death	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Nama (First, Middle, Last) 2. Data of Deeth Day Month **Physician** 1999 Woodrow Wilson Swift February 21 1996 ocation of Deeth 4c. County of Deeth /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner Baltimore Franklin Square Hos 5. Social Security Number 6. Sax Rosedale Bank Hours Min. 8. Dete of Birth (Month, Day, Year) July 20, 1920 pital enter If Under Birthplece (State or Foreign Country) Aga (In vrs. last birthday) **Funeral** Months 1X M 2□ F Days 78 216 16 9920 Maryland Director Usuel Residence of Decedent the Marylend 10d. Inside City Limits 10a State 10h Counts 10c. City. Town or Location r 28a-f show 1 ☐ Yes 2X No Maryland Baltimore Directo Essex 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code with 7 is merked other than "natural", or itema 23a or traumatic event, the Moural Examiner must be 322 Riverside Dr. 21221 USA deeth Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Yaer or Detes: WW II 14. Race - American Indian 11. Maritel Stetus Bleck. White, etc. 72 hours after 1 □ Never Married 2 □ Merried 1 ☐ Yes 2 ☑ No Specify: White Specify by 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) filed within Elementery/Secondery (0-12) College (1-4or 5+) Hygiena. Forklift Operator Can Manufacturer 9 18. Mother's Name (First, Middle, Meidan Sumama) 17. Fether's Nama (First, Middla, Last) Pages 1 end 2 should be facent of Health and Mental Heart: If Item 27 is marked of Raymond Lee Swift Blanche Townslev 2 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. informent's Neme/Reletionship (Type, Print) Edward Van Swift (Son) 741 Seawall Rd. Baltimore, Md. 21221 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, Steta 1 Burial 2 ☐ Cremetion 3 ☐ Removal from Stete Holly Hill Mem. Gardens 2/25/1999 Baltimore, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Addrass of Fecility Bruzdzinski Funeral Home P.A. 21. Signature of Funeral Servica Lice 1407 Old Eastern Avenue Essex, Md. 21221 23a. Part. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiec or respiretory errest and k, or heer failure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth **Physiclan** /Medical Immediate Ceuse (Final .Thrombosisot Aorta (Retrograde) up to Renal Arteries 2 Days disease or condition resulting in deeth) Examine Examiner Probable Sepsis and I-transit tha death certificate be axecuted Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Causa (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of): physician ar s the bunal-to c. Secondary to Infected Nortobifemorial Bypass Graft Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as esn Po signed by the a 23b. Did tobecco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 10 Yes 2 No 3 Probably 4 Unknown þ The law requires 24b. Were eutopsy findings eveileble prior to complation of cause of deeth? 24a. Wes en eutopsy performed? should Completed is certificate has director, paga 2 1 Yes 2 No 1X Yes 2□ No or Attending Physician: 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To this 28a. Dete of Injury (Month, Dey Year) funeral 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Neturel 5 Pending s effer de. 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 124 hours efter Me Funerel Direct Interest filled in b 4 ☐ Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated. 29a. Certifier edical completely (Check only one) To the I within 2 29d. Data signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number

Swift, Woodrow in

State Registrar

FEB 23 1999

Viresh 31. Dete flied (Month, Dey, Year) 9000 Franklin Square Drive Battimore, Mayland 21237 32. Registrer's Signeture

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

Pate

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to the second second 1 1,513 - 7

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) FEB 1999 **Physician** ANNE STEINBERG 20 6:35AM /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner HOSPICE OF BALTIMORE GILCHRIST CENTER BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) APRIL 18 1919 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours Min. 1 M 2 F 212-16-5366 79 MARYLAND Director Usual Residence of Decedent the Meryland 10e State 10h County 10c. City, Town or Location 10d. Inside City Limits rail, or items 23a or 28a-f show Examiner must be notified at MD BALTIMORE BALTIMORE 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Peges 1 end 2 should be filed within 72 hours efter death with 1 ent of Heelth end Mental Hygiene.
Int: If Item 27 is marked other than "natural", or Items 23s or 3 introduced or or the Mental Progress or 3 into or other treumalic event, the Medical Exertive market. 7906 TERRAPIN COURT 21208 U.S.A. Funeral 14. Reca - American Indien. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Yes 2√ No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married 1□ Yes 2□ No Specify: Specify WHITE by Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12)12 College (1-4or 5+) HOMEMAKER OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) LERNER ISAAC ROSE **HOFFMAN** 19a. Informent's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) DR. MARION FRIEDMAN/BRO-IN-LAW 7906 TERRAPIN COURT BALTIMORE MD 21208-3126 20b. Plece of Disposition (Name of MOSES MONTEFICRE WOODMOOR 2/21/99 BALTIMORE 20c. Location - City or Town, Stete 20e. Method of Disposition permit. Peges Depertment of Important: If it any Injury or on 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from State MD 4 ☐ Donetion 5 ☐ Other (Specify) HEBREW CONG. CEMETERY 22. Name end Address of Fecilia OL LEVINSON & BROS. INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD PIKESVILLE MD 21208 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) CANCER 5 years Examiner Examine Sequentially list conditions, it eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or as e consequenca of): signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 0 Records, þ The law requires 6 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed 6 his certificate hes bil director, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Vital or Attanding Physicien: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Division of this funeral 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28e. Date of Injury (Month, Dey Yeer) 1 Neturel 5 Pending hin 24 hours efter death. the Funeral Director: Al mpletely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homloide 1X Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end manner stated. 29a. Certifier Medical within 2 To the I 290. Signature and vitte of 29c. License number 29d. Date signed (Month, Day, Year) uno 25205

N. Charles St. Balton md Zizoy

State Registrar 30. Name end eddress of person who completed fause of deeth (Item 23e) (Type, Print)

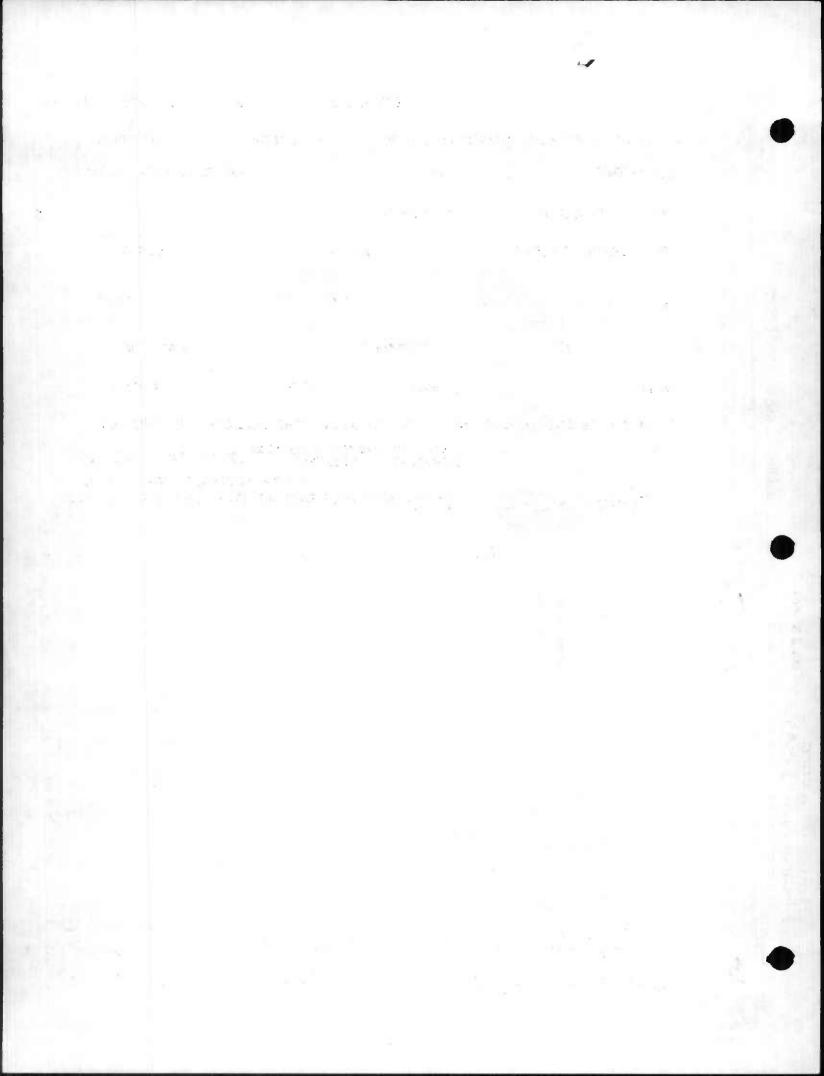
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31. Dete filed (Month, Dey, Year)

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32. Registra s Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

- part				
Certif	icate	of	Death	

	Physic /Med Exami	ical
	unera irector	
with the Maryland	a or 28a-f show Lbe notified at	Director

2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month TRA ROSS SPECTOR 2327 **FEBRUARY** 1999 P 16 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) BALTIMORE 7007 CONCORD RD. BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. DECOMP. 1950 9. Birthplaca (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) M 2□ F MARYLAND 38 Yrs. 219-66-7008 Usual Residenca of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County MD BALTIMORE BALTIMORE 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7007 CONCORD ROAD 21208 U.S.A. Funera 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status than "natural", or iter the Medical Examiner hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: SpeciWHITE à 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) DIRECTOR BALTO. CITY MARKETS 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Ilem 27 is marked of SPECTOR ROCHELLE LICHTER ALLEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 7007 CONCORD ROAD BALTIMORE MD 21208 NATALIE SPECTOR/ WIFE 20b. Ptaca of Disposition (Neme of 20c. Location - City or Town, Stete 20a. Method of Disposition SWINICHER WOLINER BENEVO 1 XBurial 2 Cremation 3 Removal from State 2/19/99 BALTIMORE MD. 4 ☐ Donation 5 ☐ Other (Specify) LENT SOCIETY CEMETERY 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE MD 21208 eurs that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate intervat Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events Due to (or as a consequence of): Physician/Medicai Due to (or as a consequenca of): resulting in death) Last 23b. Did tobacco use contribute to the cause of deeth? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed by Obesi Division of Vital Records, þ 8 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of deeth? page 2 certificate hes 1 D Yes 2 □ No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To After this 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28c. Injury et Work? 28d. Describe how Injury occurred 1 Natural 5 Pending Investigation s after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide 6 Hospital 24 hours edical 29a. Cartifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) end menner as steted. Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, end due to the cause(s) and manner stated. (Check only one) within 2 ŝ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 O.C.M.E FEBRUARY 17,1999 30. Name and a dress of person who completed cause of death (Item 23e) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

taner

32. Pegistrar's Signature

Registrar

State

ose 31. Date filed (Month, Day, Year) FEB 2 3

23

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

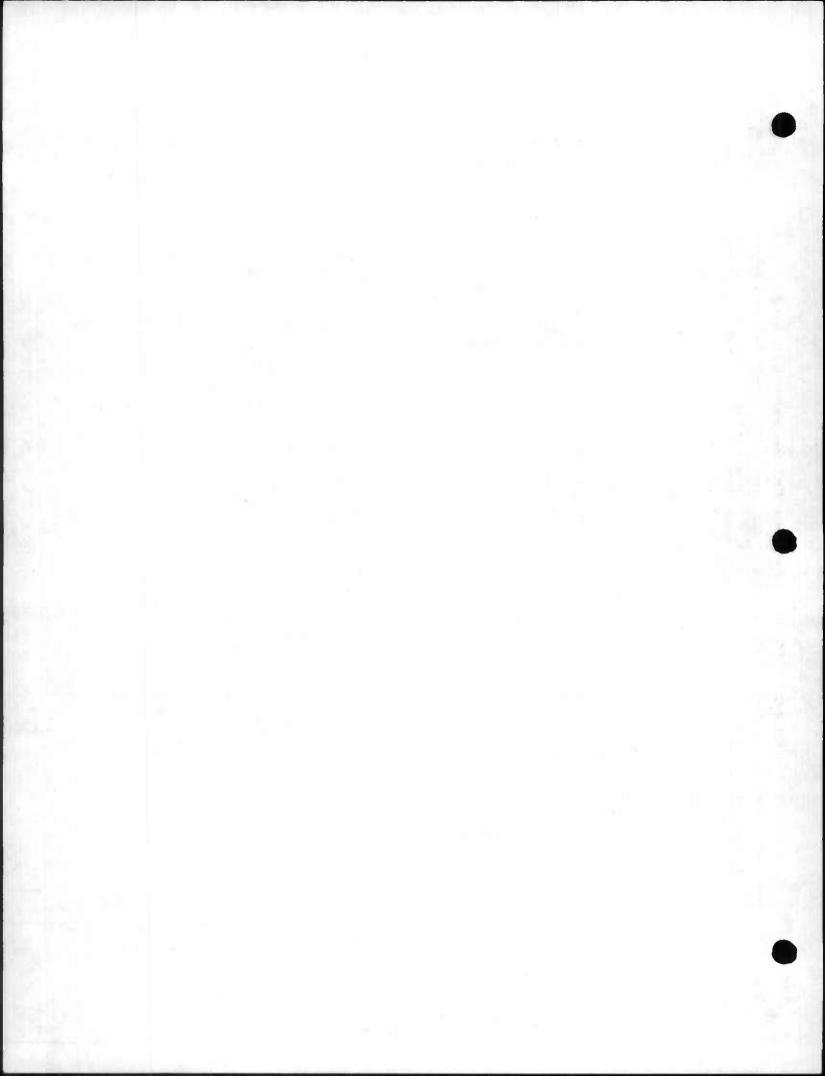
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Day **Physician** Lorraine Stites В. Feb. 21 1999 5:00pm /Medical 4c. County of Death 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3051 Riverview Road Riva Anne Arundel If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) Funeral Days 1□ M 2▼F 213-01-6517 Director 79 Apr. 18,1919 Maryland Usual Residence of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits MD Anne Arundel Riva 1□ Yes 2□No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 3051 Riverview Road 23a 21140 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Year or Dates: "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 72 hours after 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) Retail Sales Clerk Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be parmit. Pages 1 and 2 should be I Department of Health and Mental I important: If Item 27 is marked of any injury or other trainmatic eve Milton Brigerman Betty Reinke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert E. Stites - Husband 3051 Riverview Rd. Riva, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete Data 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from Stata Lakemont Cemetery 2/24 Davidsonville, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Nama and Address of Facility Hardesty Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. 21401 Approximate Intarval Between Onset and Death **Physician** Immediata Causa (Final disease or condition rasulting in death) /Medical Examiner Due to (or as a conse Examiner burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Box 68760 Completed by Physician/Medical ata has been signed by the attending p page 2 should be detached for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 → Yes 2 No 3 Probably 4 Unknown Records, 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 Ho 1 ☐ Yas 2 ☐ No certificata Division of Vital or Attending Physician: funeral director, 25. Was casa referred to medical Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Homa 5 ☐ Residence 6 ☐ Othar (Specify) Certification: To 1 Yes 2 No this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? After 1 []Natural 5 Pending 24 hours after death.

Funerel Director: A 1 Yes 2 No invastigation 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 \$ 29b. Signeture end titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) RED 30. Name and eddress of purson who completed cause of death (Item 23a) (Type, Print) 621 Ave Ste 401 Annapolis, mo-Orcgory /).
31. Data Wed (Month, Day, Year) 32. Registrar's Signatura State FEB 2 3 1999 Registrar

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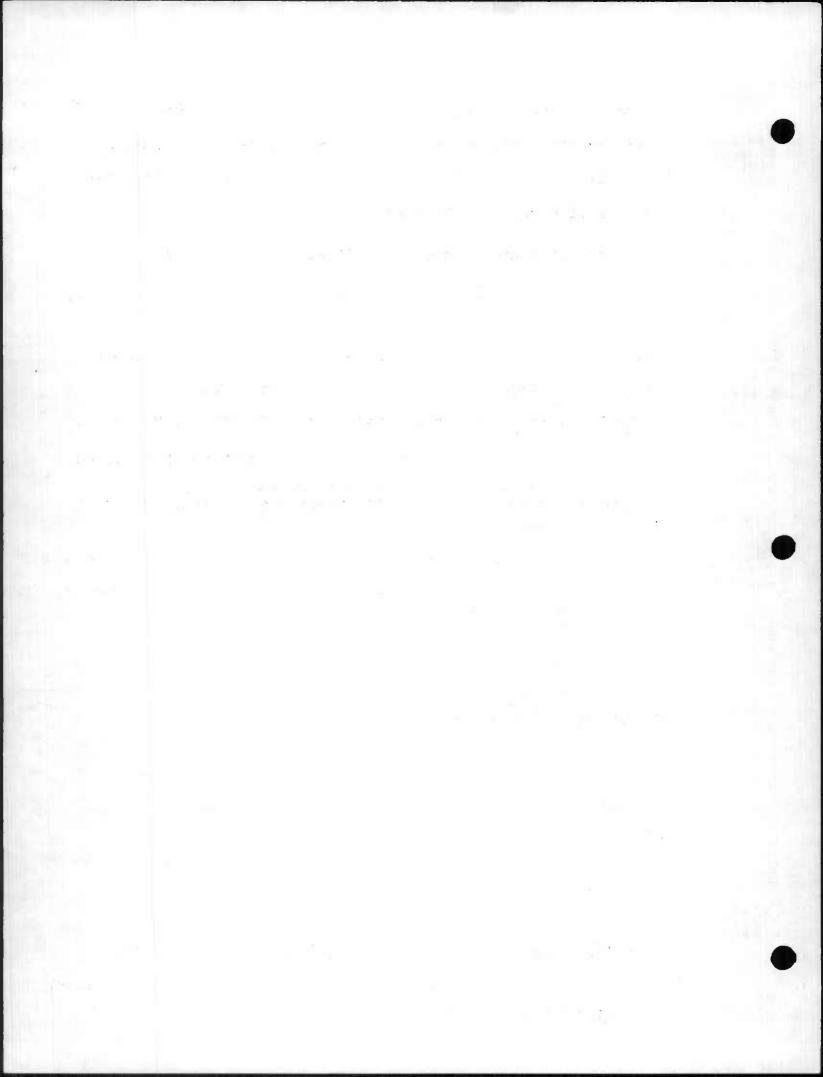
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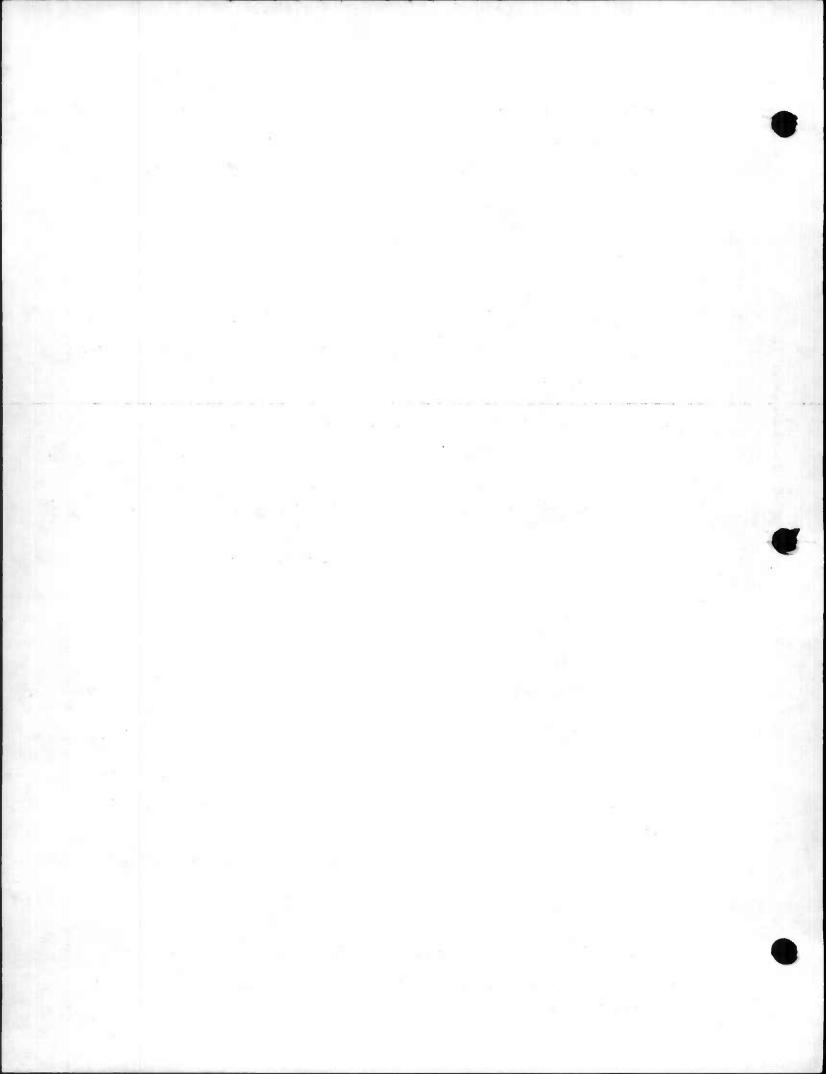
State of Maryland / Department of Health and Mental Hygiene

						Certi	ificate	of	Death		Reg. No.		Joan
	1. Decedent's Name (First, I	Aiddle, Las	st)							2. Dete of De Month	eeth Dey	Yeer	3. Time of Deeth
Physician /Medical	Carrie	e I	Bell Sa	aunde	ers					2	20	99	10:00 F
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is 1 and 2 should be filed within Health and Mentel Hygiene. Ifem 27 is marked other than other traumatic event, the Me To Be Compl	20a. Method of Disposition		,	20b. F	Place of	Disposit	ion (Name	a of		Data			Town, Stete
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permit. Pe Depertment Important: eny Injury once.	21. Signature of Funeral Sec	vice Licen	see						ess of Fecility	~ ~ ~~			
2011	R James	a.)	Vinton						. Morto			MA	01017
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00	examiner?		Hospital: 1 ☐ Inpa	atient 2	ER/Out	petient	3 DO	A Ot	her: 4 Nursing	Home 5 Hes	Idence 6	Other (Sp.	ecify)
E E E	27. Manner of Death		28e. Dete of Ir (Month, I		28b. T	ime of		Bc. Inju		28d. Dascribe			
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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

		State of Maryla		ificate of			giene Reg. No. 99	05336
Physician /Medical	HENDRA (*	ast) SCHNEIDER, S	R.			2. Date of De Month FEB . 1		3. Tima of Death 8:45 AM
Examiner	4a Facility Nema (If not institution, g				4b. City, Town, or		,	
	2106 EASTRIE		s. last birthday)	If Under 1 Yaar	TIMONIU			BALTIMORE
Funeral Director	5. Social Security Number 213-03-4285 Usual Realdence of Decedent	17. M 2□ F 95		Months Days	Hours Min		5, 1904	9. Birthplace (Stata or Foreign Country) MD.
2 B 10	10a. State 10b. County	10c. C	City, Town or Loca	ition				10d. tnside City Limits
or 28e-f show be notified at Director	MD BALTI	MORE	TIM	MUINC				1 Yas 2 No
vith the Ma t or 25s-f s be notified Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
		ROAD		2	21093			U.S.A.
020 urs after ar, or he Examine	3€ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forcas? 1	lf Y	as Decedent of H Yas, specify Cuba Yas ACXNo	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yas or No rto Rican, atc.)	Black,	Amarican Indian, Whita, atc. WHITE
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Main and 2 27 1s a strange of trans	HENRY SCHNEIDER,			EASTRIDO			ORE, MD 2	
Man other	20a. Mathod of Disposition		Place of Disposit	ion (Nama of	ce)	Data	20c. Location - C	ity or Town, State
Baltimore bemit. Pages 1: Department of He mportant: if Nen any Injury or oth abox.	Burial 2 Cramation 3		AK LAWN (2/19/99	BALTIMOR	E, MARYLAND
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= F # a o	25. Was casa referred to medical				26 Place of Do	eth (Check only		1 Yas 2 No
of Vita Physician: this certific ral director,	examiner?	Hospitel: 1 Inpatiant 2	☐ ER/Outpatient	3 DOA Oth	or-		dence 8 Othar	(Specify)
0 4 5 7		28a. Data of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui		1	how injury occurred	
E E E E	3 Suicide 6 Could not datarmine		homa, farm, stree	t, factory, office		28f. Location (City or To		r or Rural Route Number,
To the Hospital within 24 hours To the Funeral completely filled Medical C		Physician: To the best of my kr aminer: On the bests of axamir and mannar stated.						
within 3				29c. Licens	se number	0	29d. Data signed	(Month, Day, Year)
	mur The	who Phytic	iaN	D.	26534		2/17/	199
o peth	Mars Clalon	o completed causa of death (Ite	om 23a) (Type, Pr	int)	Lac Ba	14more	mo	21202
State Registrar	31. Date filed (Month, Day, Year)	32 Aegistrer's Sign	natura 6	boarto	P			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Neme (First, Middle Last) 2. Dete of Daeth 3. Time of Deeth **Physician** Trank /Medical 4a. Fecility Nema (If not institution, give street and number 4b. City, Town, or Location of Deeth Examiner Norsing Our P 159/ Filmore Urien If Under 1 Yaar If Under 24 Hrs. 5. Social Sacurity Number 6. Sax 7. Age (In yrs. last birthdey) Birthplece (Steta or Foreign Country) **Funeral** M 2□ F Deys Director UNK 217-80-5389 May 29,1961 10e Stata 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral', or items 23a or 28a-f st Examiner must be nothed 11√ Yes 2 No Director Md. N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3223 Eastern Avenue 21224 U.S.A. Funeral 12. Was Dacedent Ever in U,S. Armed Forces? 13. Wes Decadent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. Pages 1 and 2 should be filed within 72 hours efter vand of Health and Mental Hygiene.
ant: if item 27 is marked other than "natural", or item ury or other traumatic event, the Modical Examinatory or other traumatic event, the Modical Examinatory. 1 Naver Married 2 ☐ Marriad 1 ☐ Yas 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Completed by 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th 17. Father's Neme (First, Middla, Last) Painter Paint Co. 18. Mother's Name (First, Middle, Meiden Sumeme) Be Theresa A. Miller Elmer R. Sollenberger 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1399 S. Belcher Rd., Largo, Fla. 33771 Timothy Sollenberger/Bro. 20a. Method of Disposition 20b. Plece of Disposition (Neme of cematary, cremetory or other pleca) 20c. Location - City or Town, Stete Date 1 ☐ Burial 2 X X remetion 3 ☐ Ramovel from State 4 ☐ Donetion 5 ☐ Othar (Specify) 2-22-99 permit. Page Department of Important: If any Injury or Baltimore-Washington Crematory Laurel, Md. 21. Signatura of Funerel Service Liquid 22. Name and Address of Fecility Bradley-Ashton-Matthews Funeral Home, Inc. ert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

*Physician** /Medical Immediete Ceuse (Final disease or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner I or Attending Physician: The law requires that the death certificate be executed effect death.

Director: After this certificate has been signed by the ettending physician and all by the funeatild director, page 2 should be deteched for use as the burlet-transit all his than the standard director, page 2 should be deteched for use as the burlet-transit Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events rasulting In deeth) Last Due to (or es e consequença of): Be Completed by Physician/Medical Due to (or as a consequence of): Pert II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown 24b. Were eutopsy findings evelleble prior to completion of causa of death? 24a. Wes en autopsy performed? 2 No 1 Tes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 22 No 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? Certification: 27. Menner of Deeth 28d, Describe how Injury occurred 28b. Time of 1 Naturel 5 Pending investigation 2 No 1 Yes 2 Accident 6 Could not ba determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Straet and Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide To the Hospital within 24 hours e To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

DHMH 16 Rev 6/95

the Maryland

Baltimore, Maryland 21215-0020

P.O. Box 68760.

Division of Vital Records,

State Registrar

31. Dete filed (Month, Dey, Yeer) FEB 23

29b. Signatore end title of certifier

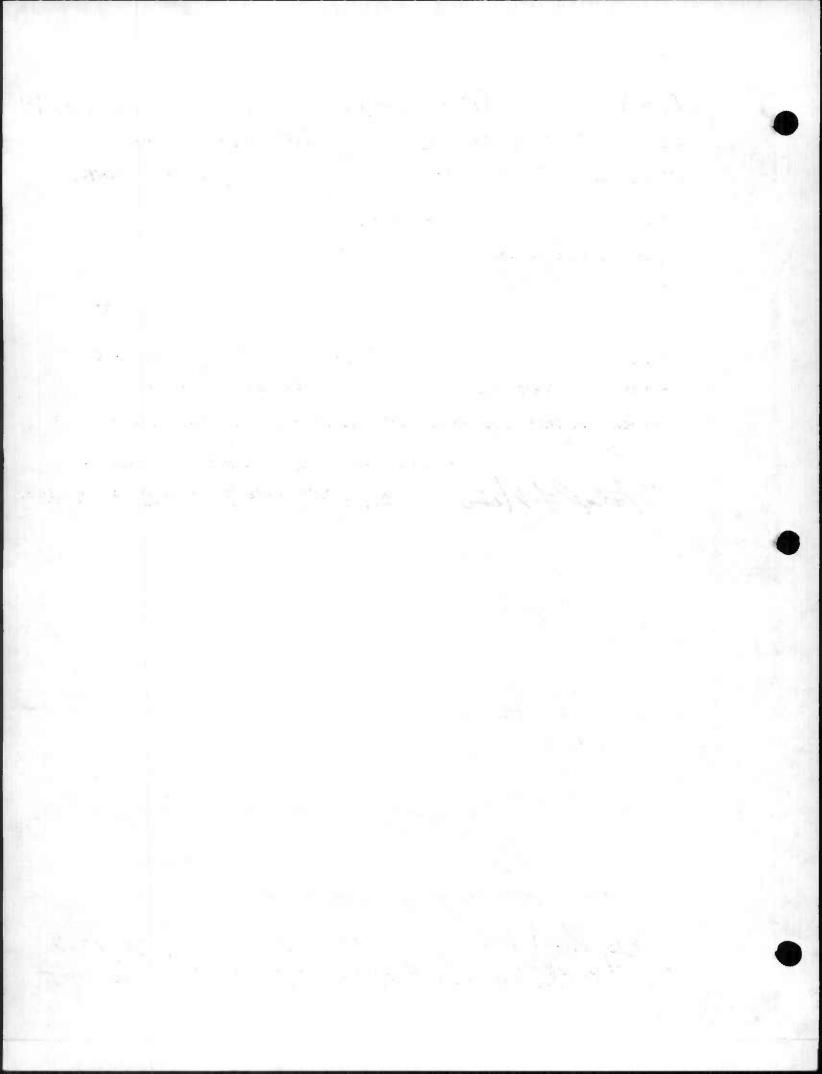
dw 32. Registrer's Signature

1999

completed cause of deeth (Item 23a) (Type, Print)

29c. License number

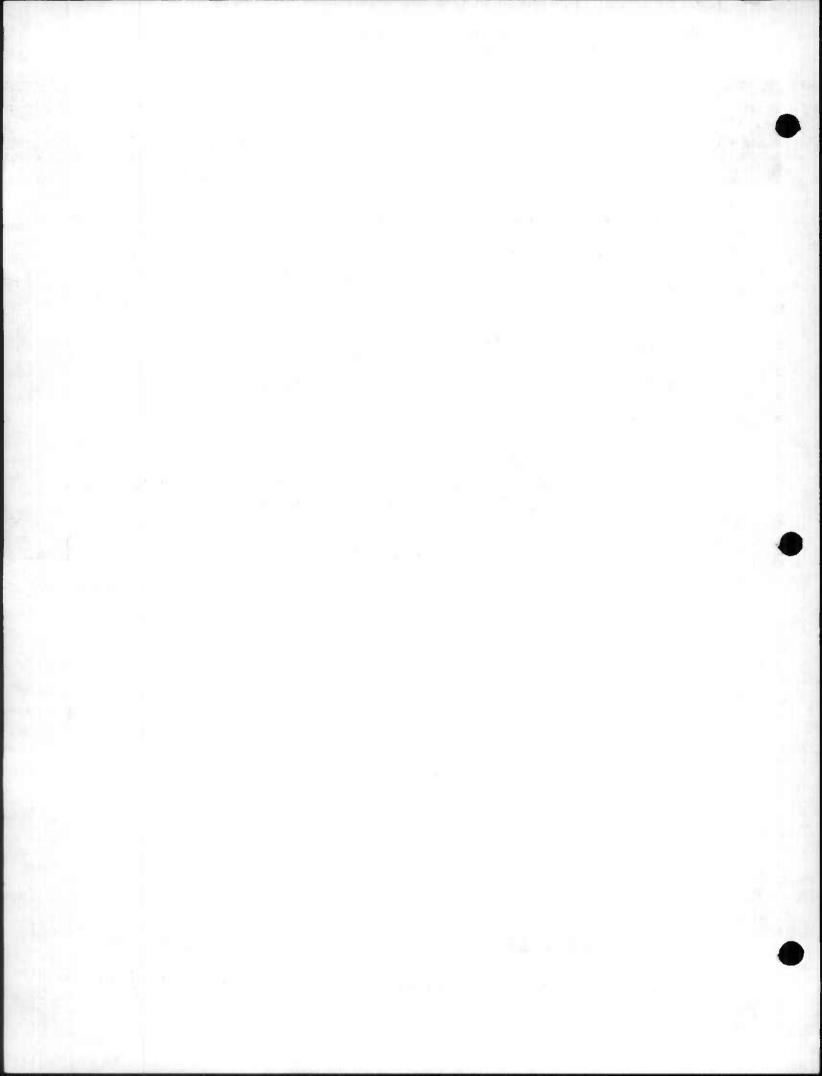
29d. Data signed (Month, Dey, Year)



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State of Maryland / Department of Health and Mental Hygiene

Physician Modified Examiner 4. Each y Name (If not sistifution, plus abred and number) 4. Each y Name (If not sistifution, plus abred and number) 4. Each y Name (If not sistifution, plus abred and number) 4. Each y Name (If not sistifution, plus abred and number) 4. Each y Name (If not sistifution, plus abred and number) 4. Each y Name (If not sistifution, plus abred and number) 4. Each y Name (If not sistifution, plus abred and number) 4. Each y Name (If not sistifution, plus abred and number) 4. Each y Name (If not sistifution, plus abred and number) 4. Each y Name (If not sistifution, plus abred and number) 4. Each y Name (If not sistifution, plus abred and number) 4. Each y Name (If not sistifution, plus abred and number) 4. Each y Name (If not sistifution, plus abred and number) 4. Each y Name (If not sistifution, plus abred and number) 4. Each y Name (If not sistifution, plus abred and number) 4. Each y Name (If not sistifution, plus abred and number) 5. Social Social Plus (If not sistifution) 5. Social Social Plus (If not sistifution) 5. Social Social Plus (If not sistifution) 1. Market Sistifution 1. Ma			1 Decedents Name (First Middle 1 1)		Ce	rtificate c	Deam	1	Reg. No.		-110000-1000
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Social Source by Number College	LAGIIII	iei	Holy Choss Hos	spital				_	,		RY
100. Clay 100.			5. Sociel Security Number 6. Sax 018 -12 - 43/6	7. Age (In y			ar If Undar 24 Hr	s. 8. Dete of B (Month, D	irth ley, Yeer)	9. Birthplece (Country)	(State or Foreig
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Commeter, cremetry, or other pieces Commeter Comm	m 27 is m 27 is her trau		UNKNOWN		UNKI	NOWN					
Baltimore, Maryland 21201 28a Part, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, inchest feature. Using only one cause on each line. Septis The disease or condition and Death Maryland Sease or condition Sease or condition and Death Maryland Sease or condition Sease or condition Sease or condition Sease or condition Sease or condition Sease or condition Sease or condition Sease or condition Sease or condition Sease or condition Sease or condition Sease or condition Sease or condition Sease or condition Sease or condition Sease or condition Sease or condition Sease or condition Sease o	ment of H ant: If its ury or of		1 Burial 2 Cremation 3 R 4 Donation 5 XOther (Specify)	emovel from State IN STATE	cemetery, cre	osition (Neme of metory or other)	ole ca)	Date	20c. Location -	City or Town, S	Stete
## Part I. Cither significant conditions contributing to death but not resulting in the underlying cause given in Part I. ## Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ### Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ### Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ### Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ### Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ### Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ### Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ### Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ### Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ### Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ### Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ### Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ### Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ### Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ### Part II. Other significant conditions can be used to be cause of death in I Type 2 In No I Type 2 In No I Type 2 In No I Type 2 In No I Type 2 In No I Type 2 In No I Type 2 In No I Typ	Depart Import any in		21. Signature of Europhi Service Licenses	ade Direct	or Ŝ B				W. Balti	more St	reet
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Due to (or as a consequence of): Due to (or as a consequence of):			disease or condition		Se	PS15				>	Week
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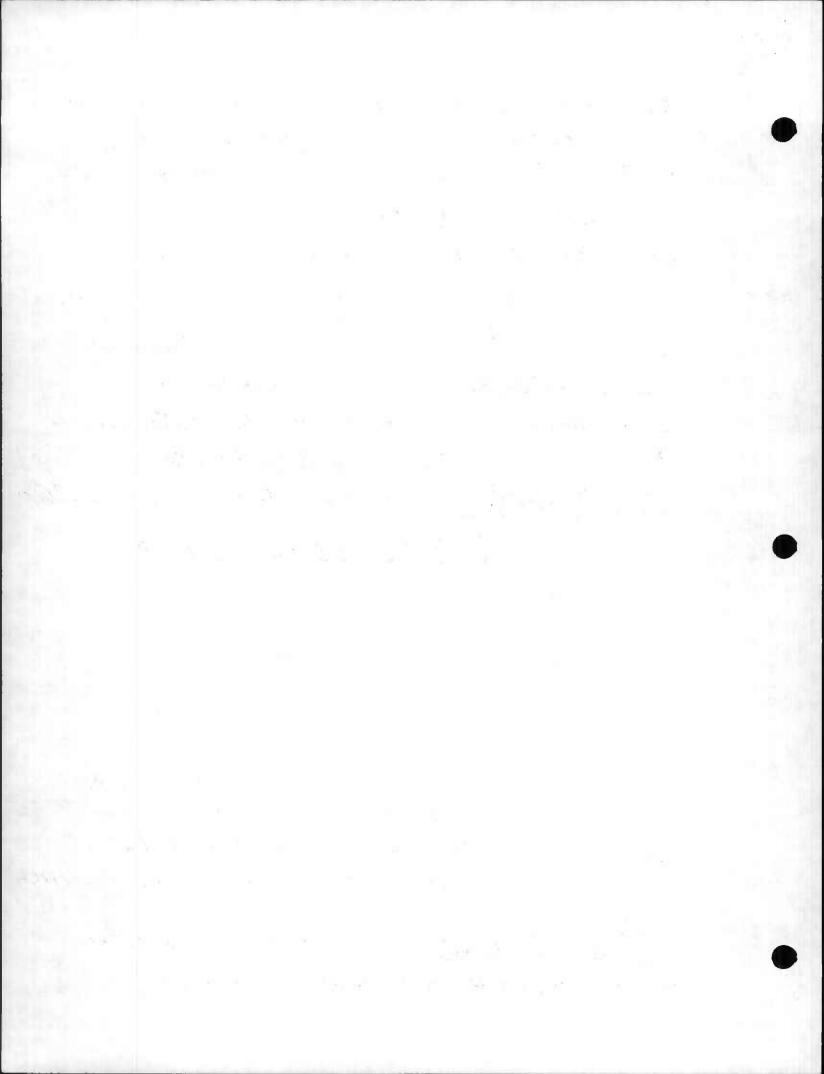


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State of Maryland / Depart

irtment of Health and	Mental Hygiene	0533
tificate of Death	Reg No.	0000

TANLEY	Certificate of Death	Reg.	No.	0000	
Physician	1. Decedent's Name (First, Middle, Last) CLEVELAND L. STANLEY. Jr	2. Date of Death	D	3. Time of Death 2:51. PM.	
Selfo, Baltimore, Maryland 21215-0020 permit. Peges 1 end 2 should be filed within 72 hours efter death with the Meryland Constitution and Construction and Construction and Construction and Policy of the traument of when the mode of the construction and plury or other traument event, the Medical Examiner and Policy. To be Completed by Funeral Director	4a Facility Neme (If not institution, give street end number) 4b. City, Town, or		4c. County of Death		
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs		9. Birth	plece (State or Foreign	
	215 92 4218 120 M 2□F 20 Yrs. Months Days Hours Min.		78	Md	
	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits	
	Md N.A. BALTO.			1 No 2 No	
	10e. Street and Number 6317 & LINORE AVE 21206	109.	Citizen of What Cou	intry?	
	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	specify: Black			
	15. Decedent's Education (Specify only highest grede completed) Elementacy/Secondary (0-12) College (1-4or 5+) College (1-4or 5+)	rking 16b	Kind of Business/Ir	a Whishow	
	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) GLENDA HAMLELL GLENDA HAMLELL				
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
	20a. Method of Disposition 1 Parial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Parial 2 Tank Parial Place	Date 200 2/26/99 B	Location - City or T	2 2 100	
	21. Signeture of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility 31 H. 1304 M. Caubal Opp				
	23a. Rand. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between				
	Immediate Cause (Final disease or condition resulting in death) a. Contout Course to Course the Course of State of State of Course of State of Course of State of Course of State of Course of State	nd of H	ead	Onset end Death	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.				
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deeth ce attendii	Pert II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobac	cco use contribute	to the cause of death?	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours eiter death. To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be deteched for use as the buriel-trensit Medical Certification: To Be Completed by Physician/Medical Examin	1 Yes 2 No 3 Probably 4 Ud			obably 4 Unknown	
		24a. Was an a performed	1? 0	Vere eutopsy findings veilable prior to ompletion of ceuse f death?	
		10 Yes	2□No 1	Yes 2□ No	
	25. Was cese referred to medical examiner? 1 🖸 Yes 2 🗆 No 26. Plece of Death (Check only one) Cher: 4 🗀 Nursing Home 5 🛣 Residence 6 🗀 Other (Specify)				
	27. Manner of Death Nature 5 Pending Investigation 28a. Date of Injury 28b. Time rt 28b. Time of Injury 28b. Time of Injury 28b. Time of				
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	29a. Certiflier (Check on one) 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, date end plece, and due to the ceuse(s) end menner as steted. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and menner stated.				
To the To the Com	29b. Signature and title of certifier 29c. License number O.C.M.E.				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1.11 Penn Street, Baltim	ore, Maryl	and 21201		
State	31. Date filed (Month, Day, Year) 32. Registrer's Signature				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month Year **Physician** 20 1999 Anthony J. Trapani, Jr. 7:40 AM FEBRUARY /Medical 4a Facility Name (If not institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Saint Joseph Medical Center Towson If Under 1 Yaar Months Days If Under 24 Hrs. 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) 12/16/1943 5. Social Security Number Birthplace (State or Foreign Country) 6. Sax **Funeral** Months Hours 110 M 2□ F MD. 55 Director 220-42-6400 Usual Residence of Decedent 10c. City, Town or Location 10a, Stata 10b. County 10d. Inside City Limits Baltimore MD. Kingsville 1 ☐ Yas 2X No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 9953 Belair Road 21087 USA Funeral 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, Whita, atc. 1 Yes 2 No If Yes, Give Yaar or Datas: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify: Specify: by White 3 Widowed 4 □ Divorced Hygiene, other than "natura ent, the Medical E 16a. Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Elsie Frances Esposito Anthony J. Trapani, 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Duane M. Trapani 118 Shrewsbury Square Yorktown, (son) 18m 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 Burial 2 Cremation 3 Ramoval from Stata 4 Donation 5 Other (Specify) 2/22/99 Hilltop Service Corp. Towson, MD., 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 211 Shorature of Funeral Service Licensee Dennis C. Carroll 1050 York Rd. Towson, MD. 21204 r the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 2 DAYS PNEUMONIA **Examiner** Due to (or es e consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events rasulting in death) Last Dua to (or as a consequence of): The lew requires that the deeth certificate below Due to (or as a consequence of) 88 by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the causs of death? signed by 1 Yes 2 No 3 Probably 4 Unknown LUNG MASS PROBABLY CARCINOMA à 24b. Were autopsy findings available prior to completion of causa of death? should I Completed 24a. Was an autopsy performed? has le 2 is certificata ha 1 ☐ Yes 2E No 2 No 1 ☐ Yes Physician: Be 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) 1□Yes 2No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Menner of Deat 28d. Describe how Injury occurred Certification: 28c. Injury at Work? After Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner es steted. 2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical

Division of Vital Records, P.O. Box 68760, Hospital or Attending To the Hospital o within 24 hours aff To the Funeral Di completely filled in

Registrar

mulli mo

29c. Licensa number

29d. Date signed (Month, Day, Year)

D 41410 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

JOGINDER P. M. D OSLER DRIVE TOWSON MARYLAND 21204 MEHTA 7601

31. Date filed (Month, Day, Year)

29b. Signatura and title of certifier

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Tima of Death 1. Decedent's Nama (First, Middle, Last) 2. Deta of Deeth ^{Day} 22,1999 Month **Physician** Bersley Holbrook Thomas February 6:30 am /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not Institution, giva street and number) Examiner VAMHCS Fort Howard Division Fort Howard Baltimore | Hundar 1 Yaar | Hunder 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) | OCT 1, 1919 9. Birthplaca (Stata or Foraign Country) Virginia 5. Social Sacurity Number 6. Sex 7. Age (In yrs. lest birthdey) **Funeral** 1∭ M 2□ F Yrs. 231-32-8372 79 Director Usuel Residence of Decedent 10e Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🕅 No notifie Directo MD Baltimore Baltimore 9 10e. Street end Number 10f. Zip Coda 10g. Citizen of Whet Country? Examiner must be r 1-C Queentree Court 21244 USA Funeral 14. Race - American Indian. 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, atc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 TYPes 2 No If Yes, Give Yaar or Datas: 1 Naver Married 2 Married Baltimore, Maryland 21215-0020 *natural", or 1 ☐ Yes 2 No Specify: by 3 ☐ Widowad 4 ♥ Divorced WW II White Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiens. Her than 'n Elementery/Secondery (0-12) College (1-4or 5+) 12 Career Soldier US Army, Retired 17. Fethar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be 7 is marked of traumatic ever and Mental John Henry Thomas Georgia Holbrook Bersley 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Hem 27 Bersley H. Thomas, Jr. / Son 5188 Dogwood Acres Drive Roanoke, VA 24019 20b. Pleca of Disposition (Neme of cematery, cremetory or other pleca) 20c. Location - City or Town, Stete 20e. Method of Disposition Deta Ŧ 1 Bunal 2 Cremetion 3 Removel from State 4 Donation 5 Othar (Specify) Department of Important: If it any injury or o MD Veterans Cemetery 2/26/99 Garrison Forest, MD 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility
MacNabb Funeral Home, P.A. 301 Frederick Road George E. MacNabb Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that causad tha death. Do not enter tha mode of dying, such es cardiac or raspiratory arrast, shock, or heert failure. List only one ceuse on each line. Approximate Interval Between Onset end Deeth **Physician** /Medical Immediata Ceusa (Final diseese or condition resulting in death) . Lung Carcinoma with Metastasis 1 month **Examiner** Due to (or es e consequenca of) Physician/Medical Examiner ettending physician and for use as the buriel-frensit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated avants resulting in death) Lest Due to (or es e consequence of): Box 68760 Due to (or es e consequence of): 23b. Did tobacco usa contribute to the cause of death? ed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings available prior to bloods 24e. Wes en autopsy Completed complation of causa of deeth? page 2 has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: 25. Wes case referred to medical examiner? Be 28. Piece of Death (Check only one) Hospitel: 1 inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No this funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury el Work? Certification: After 5 Pending To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: Af completely filled in by the fu 1 Yes 2 No death. Investigetion 2 ☐ Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 - Homicide Lixcertifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end menner as steted. 29e. Certifier Medical (Check only one) 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signeture and title of cartifier an February 22, 1999 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

State Registrar

Registrar FEB 2 3 199

Aurora C. Tan 31. Dete filed (Month, Day, Year)



Road, Fort Howard, Md. 21052

AND THE REPORT OF THE PARTY OF Charles I introduced in the confirmation of th

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Daath 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 1999 51 AM PHTI.TP TALLES FEB. 19 4c. County of Deeth 4a Facility Nama (If not Institution, give street end number) 4b. City, Town, or Location of Death 7211 PARK HTS. AVE. APT. 205 BALTIMORE 7. Age (In yrs. lest birthdey) If Undar 1 Yeer 8. Dete of Birth MAR • 25 1921 5. Social Security Number 9. Birthplece (State or Foreign 12 M 2□F Months Deys Hours MARYLAND 217-16-5728 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 1 XYes 2 No N/A 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 21208 U.S.A. 7211 PARK HTS. AVE. APT. 205 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 TNo If Yes, Give Yeer or Detes: 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes XXNo Specify: 3 Widowed 4 Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) DEVELOPER BUILDER 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) SCHOEN MOLLIE TALLES 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) LENORA TALLES/WIFE 7211 PARK HTS. AVE. APT. 205 BALTIMORE MD 21208 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremetion 3 □ Removal from State BETH TFILOH CONG CEMETERY 2/21/99 WOODLAWN 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Junaral Sarvice Licensae 22. Name and Addrass of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE MD 21208 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. tntervel Between Onsat and Death Immediate Ceuse (Finel disease or condition resulting In deeth) GLIOBLASTOMA MULTIFORME < 6 months Due to (or es e consequence of). Sequentially list conditions, if any, laading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert tt. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of causa of deeth? 24e. Was en eutopsy performed? 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical examiner? 26. Piece of Deeth (Check only one) Other: 4□ Nursing Homa 5 Residence 6 □ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

EL.T

Director

Funeral

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Completed

MD

Funeral

Director

with the Marylend

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylen Department of Health and Meniel Hygiens. Important: If itsm 27 is marked other than "natural", or itams 23a or 28a-f show any highry or other traumatic avent, the Modical Examples must be notified at pine.

Baltimore, Maryland 21215-0020

Examiner physician a Physician/Medical 65 esn for signed by the e þ been si should Completed Be

the death certificate be exe The law requires that certificate has b lirector, page 2 s or Attanding Physician: director, this Aftar death Director: 24 hours after of Funeral Directions of Funeral Directions of the Funeral Directions of the Funeral Property filled in by

Division of Vital Records, P.O. Box 68760,

To the I within 2

State Registrar

Certification: To

27. Manner of Deeth

1 Neturel

2 Accident

3 Suicide

29a. Certifie (Check only one)

4 Homicide

edicai 29b. Signeture and title of certifier 30. Name end eddress of person Tinothy L. Krohe, MD

28e. Dete of Injury (Month, Day Yeer)

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28b. Time of

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) and menner as steted.

2 Madical Examiner: On the basis of axaminetion end/or investigation, in my opinion, death occurred et the time, date end piece, end due to the cause(s) end menner steted. 29c. Licansa number 29d. Date signed (Month, Dey, Year)

N/A

no completed ceuse of deeth (tem 23a) (Type, Print)

John Hopkins at Green Spring Station 10755 Falls Rd, Suito 200, Lutherville,

28d. Dascribe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

31. Dete filed (Month, Day, Yeer) FEB 2

5 Pending

Investigation

6 Could not ba determined

32. Registra Signature Depera

Gurring . Hered was X Attitude the state of the state

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Phy 99 /N Exa

ician				CE	ertificate	of De	eatn	R	leg. No.	01	5011
IICION	_	1. Decedent's Name (First, Middle, Last,)					2. Deta of Dee		v.s.	3. Time of D
dical	_	Dorothy May	Turner					Februar	y Day 22,	1999	9:45
niner		4a. Facility Nema (If not institution, give	street end number)			4b. C	City, Town, or Lo	ocation of Deeth	4c. County		3.10
		Oak Crest Care C	enter			Pa	arkville	2	В.	Baltim	ore
ai		Social Security Number 6. Security Number	744 OFF	. lest birthday	Months I	Yaar if	Under 24 Hrs. lours Min.	8 Date of Birth			ca (Stete or I
or		212-40-64/6	3M 2X)F 82	Yrs.	Wichitio	Doys	IOUIS WIIII.	Jan. 27	, 1917	Mary	and
	-	Usuel Residence of Dacedent 10a. Stete 10b. County	100.0	ity, Town or L	continu					140	
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Director	2		imore		Parkvi						
ig	5	10e. Street end Number			10f. Zip C			1	0g. Citizan of V	Vhet Countr	y?
2	5	8800 Walther Boul				21234					State
Funeral	5		12. Was Dacedent Ever in the Armad Forces?	J,S. 13.	Was Decedar if Yes, specify	nt of Hispa y Cuban, N	nic Origin? (Sp lexican, Puarto	ecify Yes or No- Rican, atc.)		a - Amaricar k, Whita, et	
bv F		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yas 2 No If Yes, Give	16 17 190	1 □ Yes 2X	No SI	pecify:		Specify	Whit	e
			Year or Dates:	10. 0.	- d - d - 11 14						
Be Completed	0	15. Decedent's Edu (Specify only highest grade	a completed)	(Give	edent's Usuel (e kind of work) DO NOT use	done durin	n ng most of work	ing	16b. Kind of Bu	sinass/Indu	stry
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œ c	2	Ben Blackstock						Scott		•,	
To		19e. Informent's Neme/Reletionship (Ty	ne Print)	10h Mail	ling Address /	Street and		3CULL al Route Number	City or Town	State Zin C	ada)
		Irvin Turner, Sr.									
	1	20e. Method of Disposition	20b.	Pleca of Disp	osition (Neme	of	Julevar	d Apt.	20c. Location -		
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	-	4 Donetion 5 Other (Spacify)						2/25/9	9 Timon	ium,	Maryla
		21. Signeture of Funeral Servica Licanse	Timothy Ha	arman 2	2. Name end /	Addrass of	Facility	nc. Fune	ral Hom	10	
		Lunging S.	Hamw	_ 5	5305 Ha	rford	Road	Balto.,	MD 212	14	
		23a. Part1. Entar the disease, or compile shock, or haart failure. List onty or	cations thet caused tha dea	ith. Do not an	itar tha moda o	of dying, su	uch es cardiac	or respiretory arm	est,	A	Approximete
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		Immediete Ceusa (Final disease or condition	Pheuma	ma							o da
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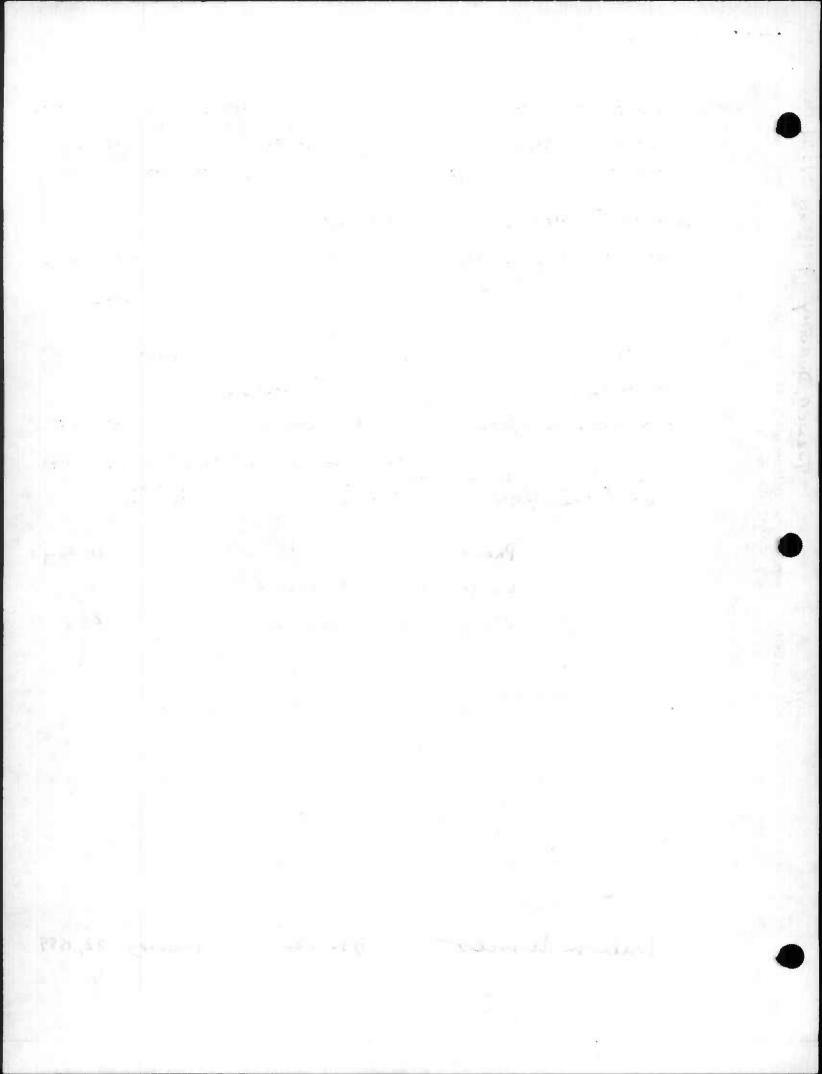
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GLENER, DOROTHY.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month 3. Time of Death Frances M. Thomas February 18 1999 3:45 P.M. 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Pleasant Living Convalescent Center Edgewater Anne Arundel 7. Age (In yrs. last birthdey) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 23, 1923 Birthplace (State or Foreign Country) Months Deys Hours 1 □ M 2 🛛 F 219 18 4805 75 Maryland Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Queen Annes Chester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 503 Swan Cove Lane 21619 U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 Never Merried 2 Married 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12th plus Supervisor of Cardiology University Hospital 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Edith MacGregor Ivan Shewbridge 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Clyde A. Thomas / husband 503 Swan Cove Lane Chester, Maryland 21619 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Buriai 2 ☐ Cremetion 3 ☐ Removel from State Glen Haven Memorial Park 2/23/99 Glen Burnie, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Servica Licansee 22. Name end Address of Fecility Gonce Funeral Home P.A. nemucustu ecome 4001 Ritchie Highway Baltimore, Md. 21225 23a. Pert1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Cause (Fine) disease or condition resulting in deeth) 6 M Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 Yes 2 No 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Wes en europsy performed? 200 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Placa of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Streturel 5 Pending 1 Yes 2 No Investigation 2 Accident

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at

127 le marked other than "n v traumatic event

. Pages 1 and 2 should be fill man of Health end Mentel Hant: If item 27 is marked off jury or other traumatic even

permit. Page Department of Important: If eny Injury or page.

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death

filed within 72 hours after

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

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Examiner siclan and burial-transit physician the buria Physician/Medical signed by the at d be detached for P Completed Be Certification: To this

Box 68760. P.O. Division of Vital Records. Attending death. n 24 hours after death we Funerel Director: A pletaly filled in by the f ò Medical To the Hosp within 24 hor To the Fune completely fi

State Registrar

DHMH 16 Rev 6/95

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

vary

6 Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Drive Cho, to, MD 2/6/9 210P N. D archo 32. Registrer's Signeture

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

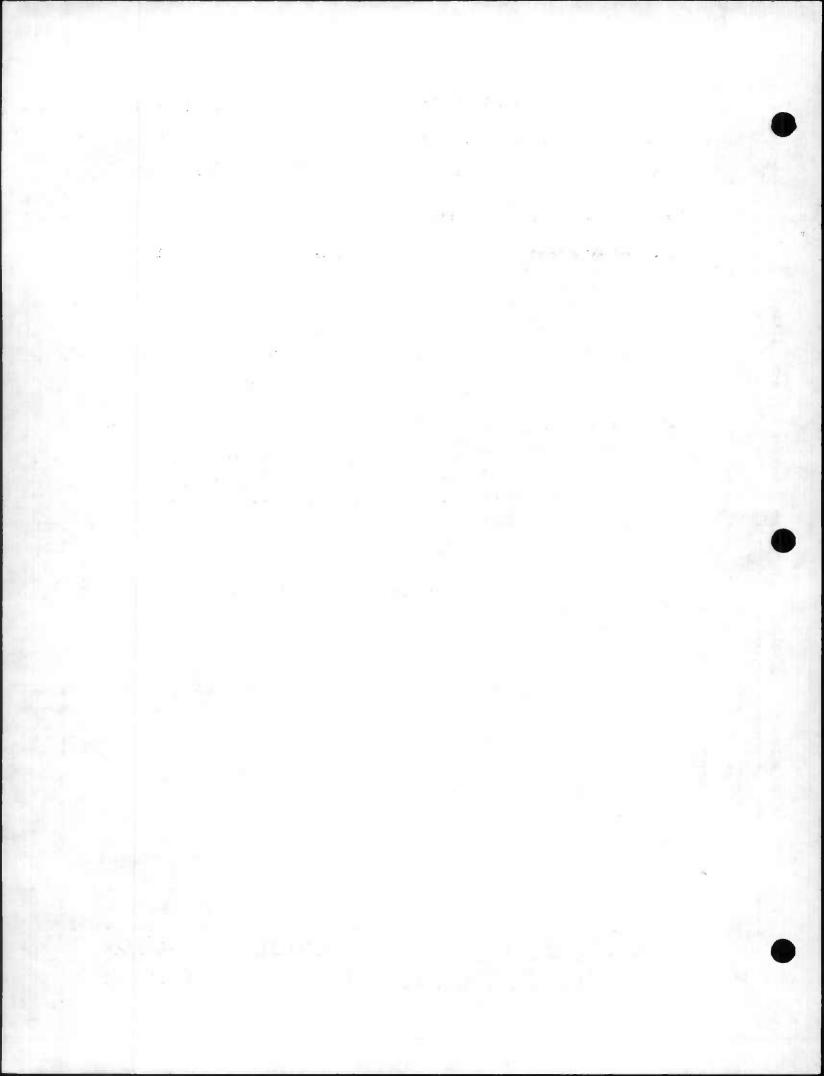
ORIGINAL

🔁 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

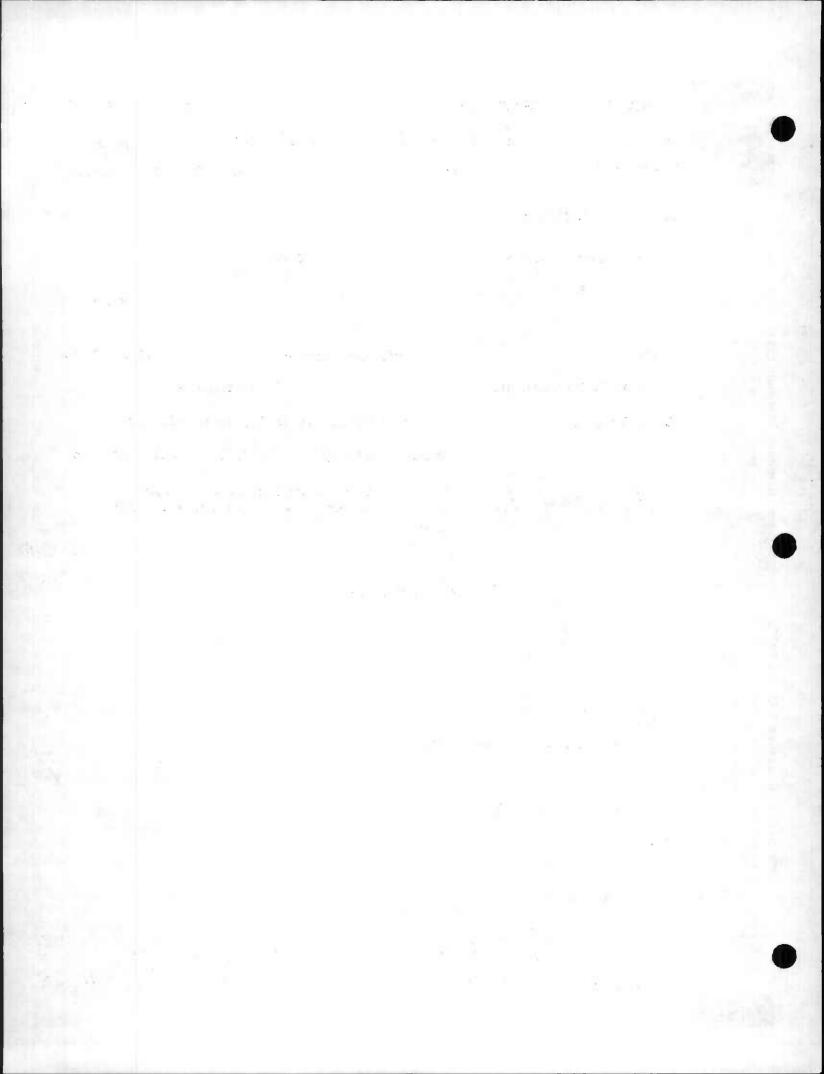
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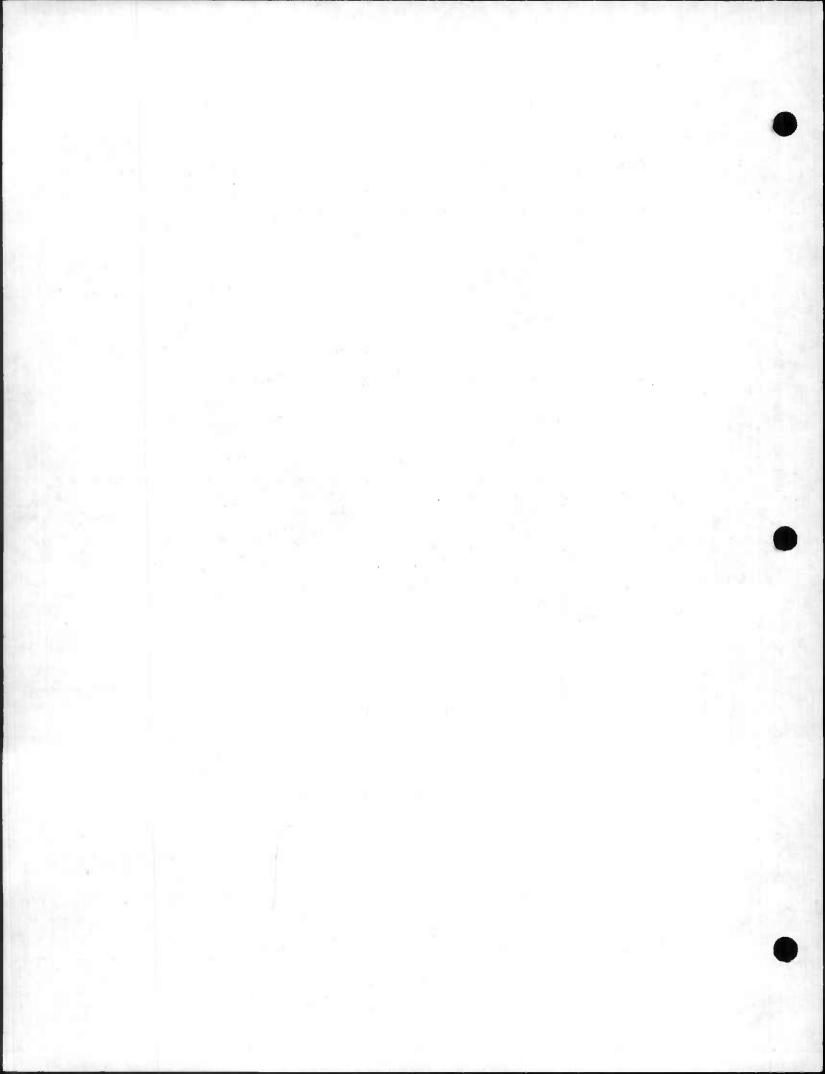
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	Dhusisian	1. Decedent's Name (First, Middle, La	ast)				2. Date of De	eth Day	3. Time of Death
	Physician /Medical		THORMANN 111				tenku		1000 1000 bild
	Examiner	4a Facility Name (If not institution, gir	ve street and number)	imore		4b. City, Town, or I	ocation of Deat	h 4c. County	of Death
		5. Social Security Number 6.	Sex 7. Aga (In	yrs. last birthday		If Under 24 Hrs.	8. Data of Bir	th	N / A 9. Birthplace (State or Foreign
ı	Funeral Director	216-42-2015	1½ M 2□ F 5		Months Days		8. Data of Bir (Month, De Mar 2	1944	Country! Maryland
	and and	Usual Residence of Decedent 10a. Stata 10b. County	100	. City, Town or L	ocation		<u> </u>		10d. Inside City Limits
	f aho	Md. Balti	more		Essex				1 ☐ Yes 🏖 No
	or 28a-f all be northful Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	Vhet Country?
	3a o	15 Francis C	Circle			21221			USA
	after death with the Marylan or items 23a or 28a-f show miner must be notified at r Funeral Director	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U,S. 13.	Was Decedent of I	Hispanic Origin? (S en, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14. Race Blac	e - American Indian, k, White, etc.
Maryland 21215-0020	5 F g	1 ☐ Nevar Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yas 2 ☑ No If Yes, Give Year or Dates:		1□ Yes 2X No				White
2-0	ed within 72 hours ygjena. nor than "natural", it, the Medical Exi-	15. Decedent's E (Specify only highast gr	ducation ada completed)	16e. Dec	edent's Usual Occu	pation during most of world)	king	16b. Kind of Bu	isiness/Industry
121	within then the Men	Elementery/Secondary (0-12)	College (1-4or 5+)					Design a	dina mada
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ary	2 should and Men is marke eumatic	19a. Informant's Name/Relationship		19b. Mai	ling Address (Stree	t and Numbar or Ru			State, Zip Code)
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ore,	of Heal of Heal fitem 2 r other	20a. Method of Disposition 1	75	cemetery, cri	osition (Nama of emetory or other pla	aca)	Date		City or Town, State
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Baltimore,	pemit. Pag Department Important: if any injury o	21. Signature of Funeral Service Lice	nsee /	11	22. Name and Addr		I IIoma s	£ Pages	
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П		23a. Part1. Enter the disaasa, or cor shock, or heart failure. List pure	plications that caused the one cause on each line.	death. Do ngt-ex	ntar tha mode of dy	ing, such as cardia	or raspiratory	errest,	Approximate Interval Between Onset end Death
1	Physician /Medical	Immediate Cause (Final	141	NII FA	1.110				
	Examiner	disease or condition resulting in death)	e	4110	unc				7 Lamonth
	<u> </u>		DA IND A	to (or es e conse	equence of):				> Inmostix
	cate be executed physician and sthe burial-transit	Sequentially list conditions.	b. Due	to (or as e conse	equence of):	->			- Julian
0,	e exe	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
68760,	death certificate be executed the attending physician and ed for use as the bunal-transit siclan/Medical Exami	that initiated events resulting in death) Last	Dua 1	to (or as a conse	quance of):		100		
	N ag		d						
Box	attendir for usa								
o.	B + 4 >	Part II. Other significant conditions			underlying cause g	iven In Part I.			ntributa to the cause of death?
٩	as that the signed by be detacted by Phy	TICORDUS	N				10	Yes 2□ No	3 Probably 4 Unknown
of Vital Records,	requires that sen signed b hould be dete	Alcoholis Aunte Ren	11 failur	0			24a. Was	s en eutopsy ormed?	24b. Were eutopsy findings evailable prior to
000	0 0	-10001 (1/07/7	a januar				реп	ormea r	completion of cause of death?
R	The law ate has page 2						1 🗆	Yes 32 No	1 ☐ Yes 2 No
ita	certificate rector, pag	25. Was case referred to medical axaminer?				26. Place of De	eth (Check only		
> >	2 00	1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatie	ent 3LI DOA		lome 5□Res	idence 6 □Oth	er (Specify)
ū	ding Ph. After th funeral	27. Manner of Deeth	28a. Dete of Injury (Month, Day Yes	28b. Time Injury	Wo		28d. Describe	how injury occur	red
sio	Attending I or death. Sector: After by the funer iffication	2 Accident investigation 3 Suicide 6 Could not be	20]Yes 2□No	006 11	(Ctanada and Alama)	
Division	Patric Te	4 Homicide determined		At home, ferm, s pecify)	treet, factory, office		City or To	(Street and Numb wn, State)	per or Rural Route Number,
_	Hospital 24 hours Funeral Italy filled	29a. Certifier 1 Cartifying Pl	hyelclan: To the best of my	knowledne dea	th occurred at the t	ime dete end plece	and due to the	ceuse(s) and ma	anner es steted
	To the Hospital or At within 24 hours after of To the Funeral Direct completaly filled in by Medical Certifi		miner: On the besis of axar end manner stated.						
	Within To the comp	296. Signature and Illia of certifier	0 - 0	/	29c. Licen	se number	44-0	29d. Date signer	d (Month, Day, Year)
	7110	1	el		2402	321-514	1175	reblend	11420,194
		30. Neme and eddress of person who	completed cause of death	(Item 23e) (Type	, Print)	adi Ho	mila	1000-	14420,1499 14mores
		SNOWNUY L-	12 M ONLO DU	-,MI) SIV	IU IJUS	MITCH	d De	MINION
	State	31. Date filed (Month, Day, Year)	32. Registrar's S	Ignáture					

State Registrar



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sician ledical	Decedent's Name (First, William Ea						2. Dete of Deal	ry ^{Da} 9, 1 <i>9</i> 99	3. Time of Death 7:21 PM
	4e Facility Neme (If not ins					4b. City, Town, or I		4c. County of Dec	
aminer	12106 Quil	-				Bowie	LOGGINOT OF DOGIN	Prince	
eral tor	5. Social Security Number 577-44-9529	6. S		ge (In yrs. last bii 9	Yrs. If Under 1 Year Months Days		8. Date of Birth (Month, Day, March 1	Year) 9. Bi	rthplace (State or Foreig
٥.	Usual Residence of Deceder 10a. State 10b. C Maryland P	County	Georges	10c. City, Tow Bowie	vn or Location	71.5			10d. toside City Limits
I Director	10e. Street and Number 12106 Quilt	Patc	h Lane		10f. Zip Code 2072	20	1	0g. Citizen of Whet C	ountry?
by Funeral	11. Maritel Stetus 1 Never Merried 25 3 Widowed 4 Div		12. Wes Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Detes:		13. Was Decedent of if Yes, specify Cub 1 ☐ Yes 2 ☐ No		pecify Yes or No- o Rican, etc.)	14. Race - Am Bleck, Wh Specify: W	
Completed	(Specify only Elementery/Secondery (0		ucation de completed) College (1-4or		Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of wor	king	16b. Kind of Business	
To Be Co	12 17. Father's Name (First, M Lawrence			ro	Bargber		ne (First, Middle, I Blanche	Maiden Sumeme)	,,,,
-	19a. Informent's Name/Rei	letionship (Type, Print)	190	b. Meiling Address (Stree	t and Number or Ru	ral Route Number	, City or Town, Stete,	Zip Code)
	Sheila Tali 20e. Method of Disposition 1 Burial 2 Crema 4 Donetion 5 Ott	ation 3 🗆	Removel from State	20b. Plece o	2106 Quilt of Disposition (Name of ery, cremetory or other plane)			, Maryland 20c. Location - City o	
	21. Signature of Funeral Se KODA	arice Licental S.	Wade, Di	rector	22. Neme end Addr State Ana Baltimore			V. Baltimo	re Street
Examiner	Immediate Cause (Finel disease or condition resulting in death)	•	e		Cance consequence of):				Onset end Death Hweeh
cal	Sequentially list conditions if eny, leading to immediac cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest	{	c	Due to (or es e	consequence of):				
sicie	Pert II. Other significant co	onditions of	ontributing to death b	ut not resulting	In the underlying cause gi	iven in Pert I.	23b. Did to	obacco uss contribu	is to the cause of death
Physician/Medica	Chr	on'c	Obstru	efive t	almonary	Biscar			Probably 4 Unknow
by							24a. Wes e		. Were autopsy findings available prior to
by							perform		completion of cause of death?
Completed by	OF Was asserted to	and the latest					1 U Y	es 2 No	of death?
Be Completed by	25. Wes case referred to m examiner? 1 □ Yes 2 ☑ No		Hospitel: 1 ☐ Inpati	ant 2 TER/O	substient 3 DOA O	hor	1 ☐ Ye	es 2 / No	of death?
To Be Completed by	examiner? 1 Yes 2 No 27. Menner of Death 1 Neturel 5 F 2 Accident 3 Suicide 6		28a. Dete of Inju (Month, Da	lry Year) 28b.	Time of injury 28c. Inju	her: 4 Nursing H ury et ork?] Yes 2 No	1 7. Yuld (Check only or lome 5 Aeside 28d. Describe hi	es 2 10 No ne) ence 6 Other (Sp ow Injury occurred treet and Number or I	of death? 1 Yes 2 No ecify)
Certification: To Be Completed by	examiner? 1 Yes 2 No 27. Menner of Death 1 Neturel 5 F P 2 Accident if 3 Suicide 6 G 4 Homicide	Pending nvestigetion Could not be determined	28a. Dete of Inju (Month, De 28e. Plece of In building, et	iny Year) 28b. jury - At home, for a contract (Specify) of my knowledge fexaminetion er	Time of injury M 1	her: 4 Nursing H	ath (Check only or lome 5 Describe had 28d. Describe had 28d. Location (St. City or Town)	es 2 No ence 6 Other (Sp ow Injury occurred treet and Number or In, Stete) euse(s) end menner	of death? 1 Yes 2 No ecity) Rural Route Number, es stated.
To Be Completed by	examiner? 1 Yes 2 No 27. Menner of Death 1 Wheturel 5 F 2 Accident if 3 Suicide 6 C 4 Homicide 29e. Certifier (Check only 2 Me	Pending nvestigetion Could not be determined ortifying Phy- dical Exam	28a. Dete of Inju 28a. Dete of Inju (Month, De 28e. Plece of In building, el	iny Year) 28b. jury - At home, for a contract (Specify) of my knowledge fexaminetion er	erm, street, factory, office e, deeth occurred at the tod/or investigation, in my	ther: 4 Nursing Horizont? Yes 2 No ime, date end place opinion, deeth occurse number 26 28	ath (Check only or forme 5 Preside 28d. Describe he 28f. Location (Single or Town), and due to the curred at the time, d	es 2 No ence 6 Other (Sp ow Injury occurred treet and Number or In, Stete) euse(s) end menner	of death? 1 Yes 2 No ecity) Pural Route Number, as stated. ue to the cause(s)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMOre aven wood Home Nursing 7. Age (In yrs, last birthday) If Under 1 Year 5. Social Security Number 214-26-4902 1 9 M 2 □ F Months Days Hours 7 UNKNOW! Usual Residence of Decedent 10b. County City, Town or Location 10d. Inside City Limits 1 Yes 2 No NA nore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent Ever in U.S. Armed Forces? I yes 2 No If Yes, Give Year or Dates: Un Knocon 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11. Marital Status 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1□ Yes 2 No Spacify Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry unknown Elementery/Secondary (0-12) Known unknown 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumama) Unknowr unknown 19a Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) TONYO KC 20a. Method of Disposition -Gyardian 1000 20b. Place of Disposition (Nama of cematery, cramatory or other place, Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2100 2-22-49 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gilmon Strel 638 23a art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heef failure. List only one cause on such line. Approximete Intervel Between Onset and Death ATHEROSCEEROTIC CARDIOVALLIAR Immediate Cause (Final disease or condition resulting in deeth) INFARCTION 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings evellable prior to completion of cause of death? 24a. Was an autopsy performed?

Physician /Medical Examiner

and

attending physician a for use as the burial-

this certificate has been signed by rail director, page 2 should be detact

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I

The law requires that the death certificate be execu

Records, P.O. Box 68760.

Division of Vital

Examiner

Physician/Medicai

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Completed

Be

Medical Certification: To

Physician /Medical

Examiner

10a State

Funeral

Director

28a-f show want be notified at

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"natural", or items 23a

traumatic event, the Medical Examiner

permit. Pages 1 and 2 should be filed within Copenheart of Health and Mantal Hygiena. Important if flem 27 is marked other than any finding or other trainment.

death

Baltimore, Maryland 21215-0020

Director

Funeral

þ

Completed

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury thal initiated events resulting in death) Last

t II. Other significant	conditions contributing to death but	t not resulting in the underlying co	ause given In Part

1 Yes 1 ☐ Yes 25 No 25. Was case referred to medical examiner? 26. Place of Death (Check only ona) Other: 4 Urursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how Injury occurred

27. Manner of Death 1 Accident

5 Pending investigation

28a. Date of Injury (Month, Day Year) 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29e. Certifier

3 Suicide

4 | Homicide

10 Certifying Physician: To the best of my knowledge, death occurred at the time, dale end place, and due to the cause(s) and menner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

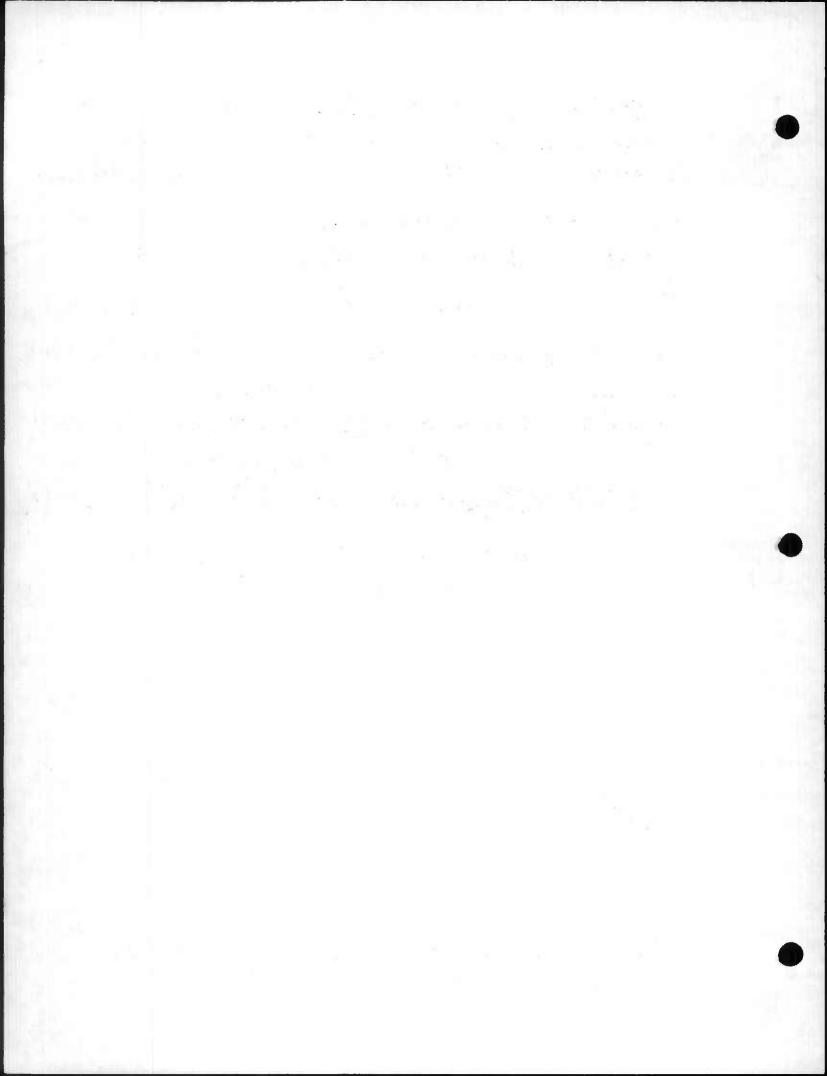
30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) FEB 2 3 1999 32 Registrar's Signature

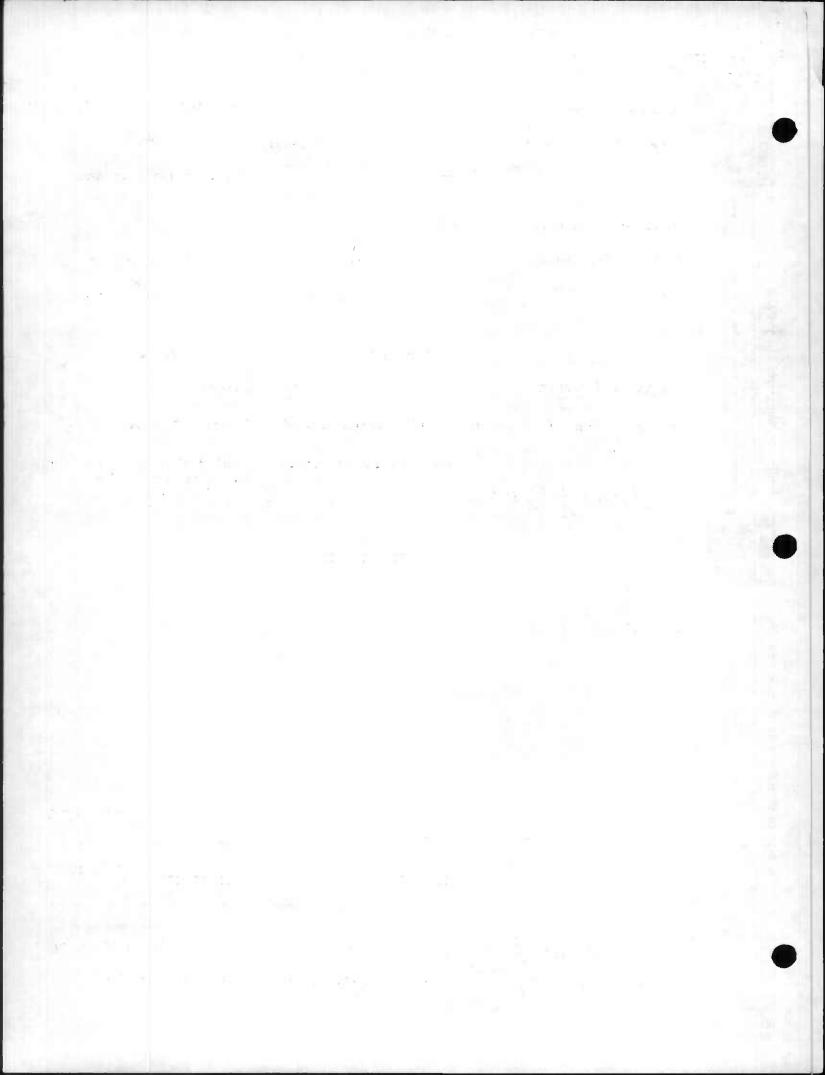
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Registrar

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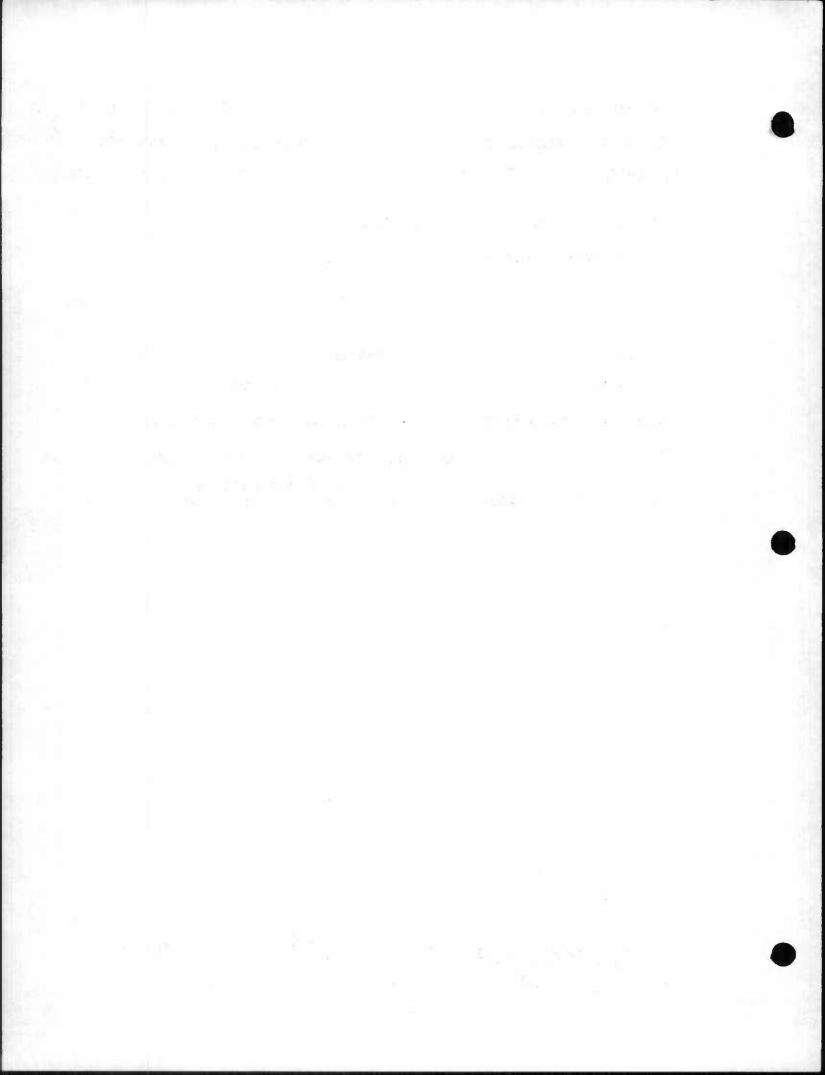


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RAYMOND IT	EMS: #23A, 27,28A-F PER em#7 perFHG768 2/23/99 E			rtment of tificate of			giene Reg. No. 9	05	348	
	1. Decedent'a Name (First, Middle, Last)				2. Dete of Dee	eth Dey	Yeer	3. Time of Deeth	
Physician /Medical	Raymond Vendemia					FEBRUA		99	02:00 AM	
Examiner	4e Fecility Neme (If not institution, give	street and number)			4b. City, Town, or	Location of Deeth	4c. County	of Deeth		
	ROUTE 70 and ROU	TE 29			Columbia		HOWAF	RD		
Funeral Director	GNK	7. Age (In y	rs. last birthday) Yrs.	Months Deys		. (Month, Da)	y, Year) 15,1957	Country		
the Meryland 28a-f show nothed at	Usuel Residence of Decedent 10e. Stete 10b. County		City, Town or Loc	cation	7			100	f. Inside City Limits	
vith the Me t or 28a-f a be not me	Maryland Baltimor	e Ba	altimore	10f. Zip Code			10g. Citizen of V	Vinet Country	y?	
th with 23a or				21207			United S	Statos		
items items		12. Wes Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give	If	Vas Decedent of	Hispenic Origin? (seen, Mexicen, Pue	Specify Yes or No-	14. Rece	k, White, et	n Indian, c.	
ours cours d by		Yeer or Dates:								
Maryland 21215-0020 d 2 should be filed within 72 hours efter de th and Mental Hygiene. The marked other then 'natural', or frem traumatic event, the Medical Expression To Be Completed by Fune	15. Decedent's Edu (Specify only highest grad		(Give	OO NOT use retir	a during most of wo	orking	plumb		stry	
d 2 Hygie dynamic mit.	17. Fether's Neme (First, Middle, Last)		plumb	er	18 Mother's Ne	eme (First, Middle,	1	0		
E Saby W	Atilio J. Vendemia				Bernice	Kujawa				
Mar 2 sh 2 sh 1 sand 1 sand	19e. Intorment's Name/Reletionship (T)				at and Number or F					
	Atilio J. Vendemia		1557 b. Plece of Dispos		Road, B				21207	
Pages 1	20e. Method of Disposition 1 ☐ Burial 2 ☑ Cremetion 3 ☐ F		cemetery, cren	natory or other pl	ace)	Dete	20c. Location -	City or Tow	n, Stete	
Limen Partition Jury	4 Donetion 5 Other (Specify)		ort Line			2/18/99				
Baltimore, permit. Pages 1 ar Department of Hea Important: if item; any injury or other	21. Signeture of Funerel Service Licens	Zink			Ва	20 Wilke ltimore,	ns Avenu Marylaı	1e	ne 1229	
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Vital Records, P.O. Box 68760, Iclan: The law requires that the death certificate be executed certificate has been signed by the ettending physician and rector, page 2 should be deteched for use as the buriel-transit ector, page 2 should by Physician/Medical Examiner	ceuse. Enter Underlying	o	o (or es e conseque)							
I Records, P.O. Box 68760. The law requires that the death certificate be ate has been signed by the attending physicial page 2 should be deteched for use as the bur. Completed by Physician/Medical	Part II. Other significant conditions con	stributing to death but not	resulting in the ur	nderlying cause g	given in Part I.		tobacco uae cod Yes 2□ No	ntribute to 1	tha cause of death	
al Records, F : The law requires the cate has been signed , page 2 should be del Completed by P						24e. Wes	en eutopsy med?	24b. Were eutopsy tin eveilable prior to completion of cer of deeth?		
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Physical dispersion of Tr. To	27. Menner of Deeth	28a. Date of Injury	28b. Time of	P 28c. inj					SCENE	
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Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours efter death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	29e. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my iner: On the basis of exemend manner stated.	knowledge, deeth	occurred et the		e, end due to the	ceuse(s) and me	nner aa ata		
Me outh	29b. Signeture end title of certifier	./		29c. Licer	nse number		29d. Date signe	d (Month, D	ay, Year)	
F 3 F 8	Theoden U.	fory-)	OCM			FEBRUAR			
	30. Name and address of person who co	inf	111 Pe		et, Balt	imore, Ma	aryland	21201		
State Registrar	31. Dete tiled (Month, Day, Year)	32. Registrer's S	gneture	B. ,	books					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of M	arylaric		tificate			,	Reg. No.	05	349
Physic	ian	1. Decedent'a Neme (First, Middle, Las	t)						2. Dete of De Month	eth Dey	Yeer	3. Time of Deeth
/Medi		HELEN C. V	ALIS						02		999	2:45 AM
Exami	ner	4a. Facility Nama (If not institution, give	o dimension of				4b	. City, Town, or L	ocation of Deet	h 4c. County	of Death	
1		ST. JOSEPH'S NUR	SING HOME					CATONS			IMORE	
Funeral Director		213-03-7231	THE OWNER	ge (In yrs. le	est birthday) Yrs.	If Undar 1 Y Months Do	ear	Hours Min.	8. Date of Bir (Month, Da OCT.	th ly, Year) 11,1907	9. Birthpla Countr MAR	aca (State or Foreign y) YLAND
death with the Maryland rms 23s or 28s-f show Linest be notified at		Usuel Residence of Decedent 10a. State 10b. County	_	10c. City,	Town or Lo	cation					10	d. Insida City Limits
the Ma	cto		N/A		BALT	IMORE						1 No Yas 2 No
vith the Maryla or 28a-fahor be notified	Director	10e. Street and Number				10f. Zlp Co	da			10g. Citizen of V	Vhet Countr	y?
ath w	<u>a</u>	3426 CHESTERFIELD					121				S. A.	
j 22	by Funeral	11. Maritel Stetus 1 □ Never Married 2 □ Merried 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☒ If Yas, Give Yaer or Detes:	?		Vas Dacedent Yes, specify (☐ Yes 2 🔯		panic Origin? (S) , Mexican, Puerto Specify:	pecify Yas or No Plican, etc.)	Specify	e - Amarica ck, White, e	
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e, M		WENCESLAUS J. VAL	IS (SON)		7 EDG	EVIEW	ROA	D, TOWS	ON, MARY	YAND 212	86	
ges 1 y H item or oth		20e. Method of Disposition 1	Damaual from Chata	20b. Ple	ece of Dispos matary, crem	sition (Neme o	f plece)		Data	20c. Location -	City or Tow	m, State
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Baltimore, N permit. Pages 1 and Department of Health Important: if item 27 any injury or other it		21. Signetura of Funaral Service Licens	0000		SC		K F	UNERAL		_	T AND	21212
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6		30. Name and eddress of person who c	ompleted cause of d	leath (Item :	23e) (Type, F	Print)	2d	nide Me	V. Ro	2/19/9 Union	212.	35':
Sta	te	31. Date filed (Month, Day, Year)	32. Registr	er's Signatu		, ,,			un			
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month 99 10:45AM larence D. Winston 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore
If Under 24 Hrs. 8. Date of HOSPITa
7. Age (In yrs. last birthday) Baltimore City Baltimore VA Birthplace (State or Foreign Country) 6. Sex If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) Months Days Hours 1₩ M 2□ F 82 230-07-4260 05-12-16 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County MYes 2 No MD NA Baltimore 10g. Citizen of What Country? 10e. Street end Number 10f Zip Code 21217 USA 1617 Division Street Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black. White, etc. XXYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed X Divorced 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade College Student Self-employed Chef 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Golder Harper Winston, Sr. Frank 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 21218 19a. Informant's Name/Relationship (Type, Print) 123 W. 29th. Street Baltimore, Maryland Catherine Winston 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State MD 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest VA Cem. 02-24-99 Owings Mills, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signatura of Funeral Service Licen-WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) · Metastatic Prostate Cancer Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as e consequenca of): Due to (or as a consequence of): resulting in deeth) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury at Work? 5 Pending investigation 1 Waturai 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred et the time, dete and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, end due to the cause(s) and manner stated.

(Type, Print)

32. Registrar's Signature

29c. License number

Illiams, 10 North Greene St. Ba

29d. Date signed (Month, Day, Year)

Examiner The law requires that the death certificate be executed physician and s the buriel-trans Division of Vital Records, P.O. Box 68760 attending p signed by the a been sig has ye 2 s this certificate or Attending Physician: After death. Director: / efter Hospital 24 hours To the Func

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23s or 28s-f show solds! Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours efter a ment of Health and Mental Hygiene.
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Physician

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Physician/Medical Examiner

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Certification:

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29a. Certifier

(Check only one)

Name and add

29b. Signature and title of certifie

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31. Date filed (Month, Day, Year)

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FEB 23

Baltimore, Maryland 21215-0020

Director

Funeral

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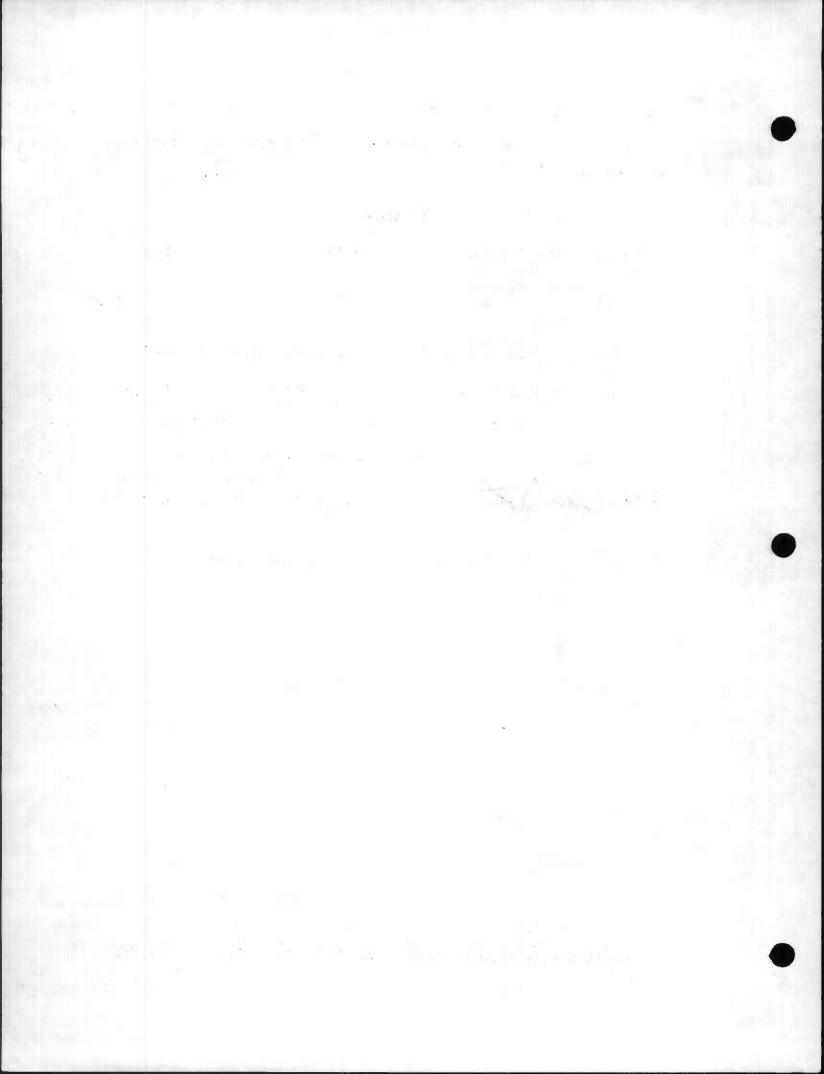
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month 48 A 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Deeth 4c. County of Death Geriatric cer Sex 7. Age (In yrs. last birthday) HALL center 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) NC 8. Date of Birth (Month, Day, Year) Months Min 1₩ M 2□ F 80 Days Hours 07-08-18 243-20-2251 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Baltimore MD NA Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt. #2-D 21237 USA 9210 Oswaloway 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 Yes 2 X No Specify: Specify: Black **X** Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NA Long Shoreman Stevedore Co. 3rd. Grade 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Ellen Worsley Worsley Levi 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 20772 11400 Treton Court Washington, DC Ella Scott 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 XBurlat 2 Cremation 3 Removal from State Woodlawn Cemetery 02-13-99 Woodlawn, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue LOW 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart teilure. List only one cause on each line. Approximate Interval Between Onset end Deeth Alteroscientic Cardiovascular Disease Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): ongestivo heart barline Congestive Due to (or as a consequence of): ascular Differe Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Wes en autopsy performed? completion of cause of death? 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one)

Physician /Medical Examiner

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Division of Vital Records, P.O. Box 68760,

permit. Page Department of Important: If any Injury or once.

Physician

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7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after ent of Heelth and Mantal thygiene. Int I fem 27 is marked other than "natural", or ite iny or other traumatic event, The Medical Experies iny or other traumatic event, The Medical Experies

Baltimore, Maryland 21215-0020

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Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Physician/Medical

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

examiner? 1 Yes 2 No 27. Manper of Death 5 Pending investigation 1. Natural

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year)

Hospital:

28b. Time of

28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

3 Sulcide

4 Homicide

Certifying Phyaician: To the best of my knowledge, death occurred et the time, date and placa, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Elaun

31. Date filed (Month, Day, Year)

6 Could not be determined

FEB 23

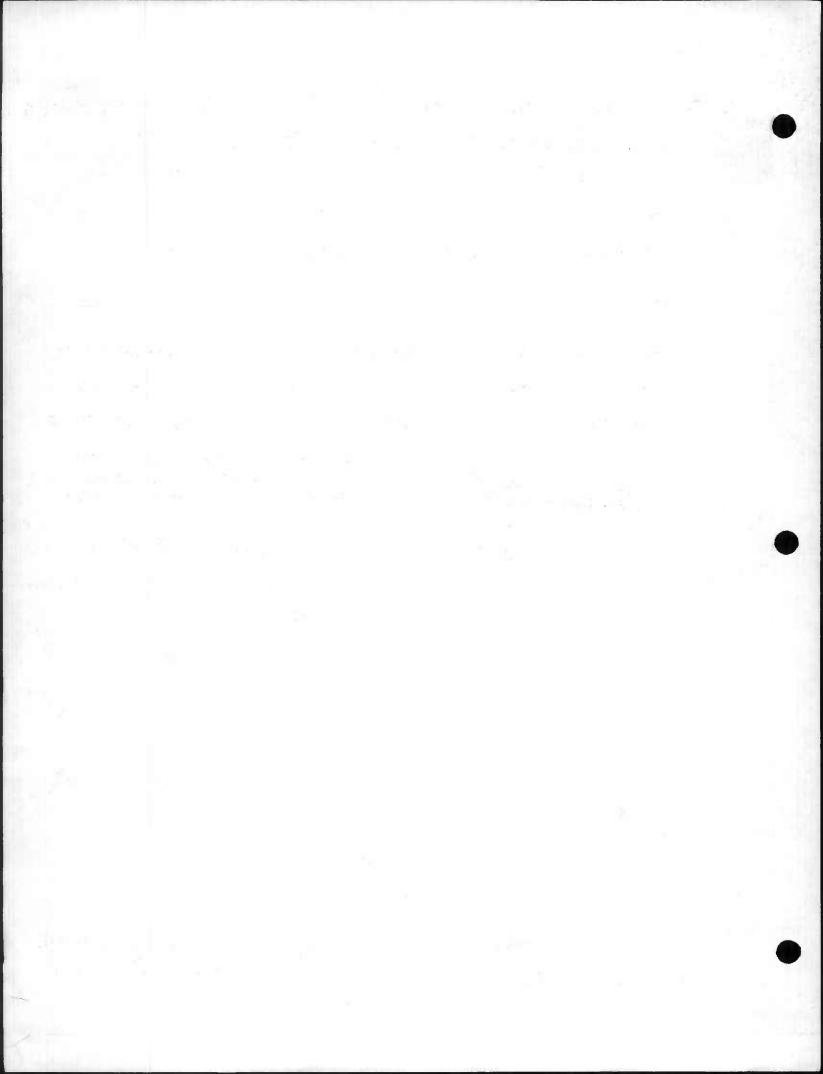
29c. License number 30641 29d. Date signed (Month, Day, Year) February 22 1999.

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) RAMESH SABAPATIM SUITE 308 821

N. EUTAW ST. BALTIMOREMO 21201.

State Registrar

32. Registrar's Signature 1999



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Yeer WARD. FEDRUMONTH Y ISIAH 4:40 AM 4b. City, Town, or Location of Deeth 4e. Facility Neme (If not institution, give street and number) 4c. County of Deeth BALTIMORE. CENTER RANDALLS TOWN HOSPITA L NORTHWEST 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1**X** M 2□ F Months Deys Hours Min. 224-34-6036 07 V.A Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Wes 2 No MD Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1400 Valley Crest Ave 21209 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bieck, White, etc. 1 XYes 2 ☐ No If Yes, Give Yeer or Dates: 1 Never Merried Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Park Lynn Apts. 12th grade Maint. Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Richard Ward Mary Parker 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis C. Ward-Wife 1400 Valley Crest Ave, Baltimore Md 21209 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Buriei 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) MD Nat'l Mem. Park 2/23/99 Baltimore, Md 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility March F/H West 4300 Wabash Ave, Baltimore Md 23a. Pert 1. Epier the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heap failure. List only one cause on each line. 21215 Approximete Intervat Betw Onset end Death Immediate Cause (Final disease or condition resulting in deeth) SEPSIS Due to (or es e consequence of): HIMOMUBY Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting In deeth) Lest Due to (or es e consequence of) Due to (or as e consequence of). Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION 24b. Were autopsy findings evelleble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? CEREBROVASCULAR ACCIDENT 1 Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Menner of Death 28e. Dete of tnjury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

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Physician

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29b. Signature and title of celtifier

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permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health end Mantal Hygiena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Macical Exercises must be not filed at once.

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> State Registrar

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AVVERAHALLI 31. Dete filed (Month, Day, Year) FEB 23

HARISH M 32. Registrer's Signeture 1999

HOUSE

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

PHYSICIAN

Certifying Phyalcian: To the best of my knowledge, death occurred et the time, date end pleca, and due to the cause(s) end menner es steted.

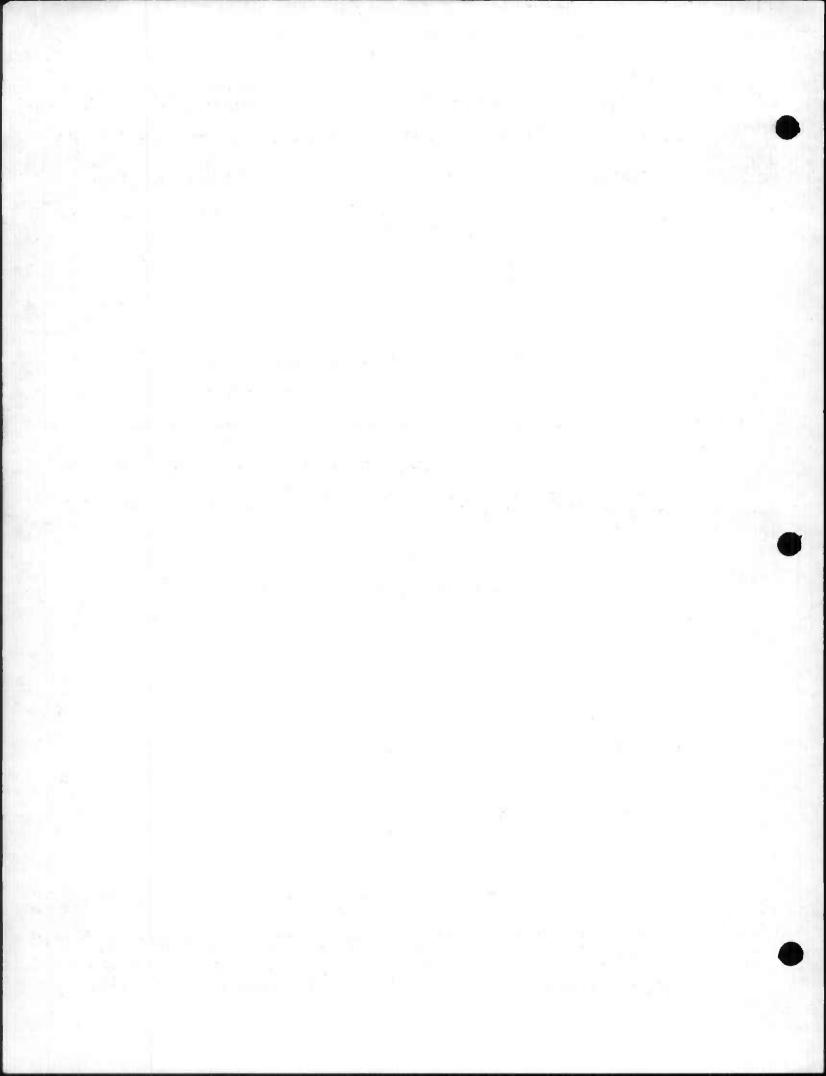
2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and menner stated.

29c. License number

042723

FOXFORD STREAM

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedant's Nama (First, Middla, Last) 3. Time of Death Month MILTON WHITE 99 2:35 AN 2 20 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Bq If Under Nursing 01 LEUNDALE 9 9. Birthplaca (Stata or Foraign 5. Social Sacurity Number 8. Data of Birth Days 10 M 20 F 10-438 Usuat Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 XYas 2 □ No Maryland nore 10f. Zip Coda 10g. Citizan of What Country? 10e. Street and Number di d 12. Was Dacadant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian. Black, Whita, atc. 1 X Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 Marriad 1 Yas 2 No Specify: 3 Widowad 4 □ Divorced Hmerican 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Etamantany/Secondary (0-12) Collega (1-4or 5+) d 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) enora George (Brother) 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) Mr. George 20b. Place of Disposition (Nama of camatary, cramatory or other Data 20c. Location City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata Mem. Par 4 □ Donation 5 □ Other (Specify) 21. Signatura of Funaral Service Licenses 22. Nama and Addrass of Facility Joseph 2222 W Ave W. North 6 Salto It is a disaasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, rhear, ailura. List only one cause on each line. Approximata Intarval Batween Onsat and Death Immediata Causa (Final disaasa or condition rasulting in daath) AMYTROPHIC SCLEROSIS LATERAL 2 YEARS Dua to (or as a consaguance of): Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or Injury that initiated avants rasulting in death) Last Dua to (or as a consaguance of): Dua to (or as a consaquanca of): 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Onknown 1 Tyes 2 No HYPERTENS 101) 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yas 2 No 1 ☐ Yas 2 ☐ No 26. Placa of Death (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA

/Medical Examiner physician and the burial-transit requires that the deeth certificate be axecuted Division of Vital Records, P.O. Box 68760, 88 use signed by the e

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Baltimore, Maryland 21215-0020

25. Was casa rafarrad to medical axaminar? 1 Yas 2 No 27. Mannar of Death

2 Accident

3 ☐ Suicida

29a. Certifiar

4 Homicida

5 Panding invastigation

28a. Data of Injury (Month, Day Yaar)

28b. Tima of

28c. Injury at Work?

1 Tas 2 No

28d. Dascribe how Injury occurred

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify)

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

(Check only one) 2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29b. Signatura and titla of certifian

29c. Licansa number

29d, Data signed (Month, Day, Year)

mathe 30. Nama and address

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who complated causa of death (Itam 23a) (Type, Print)

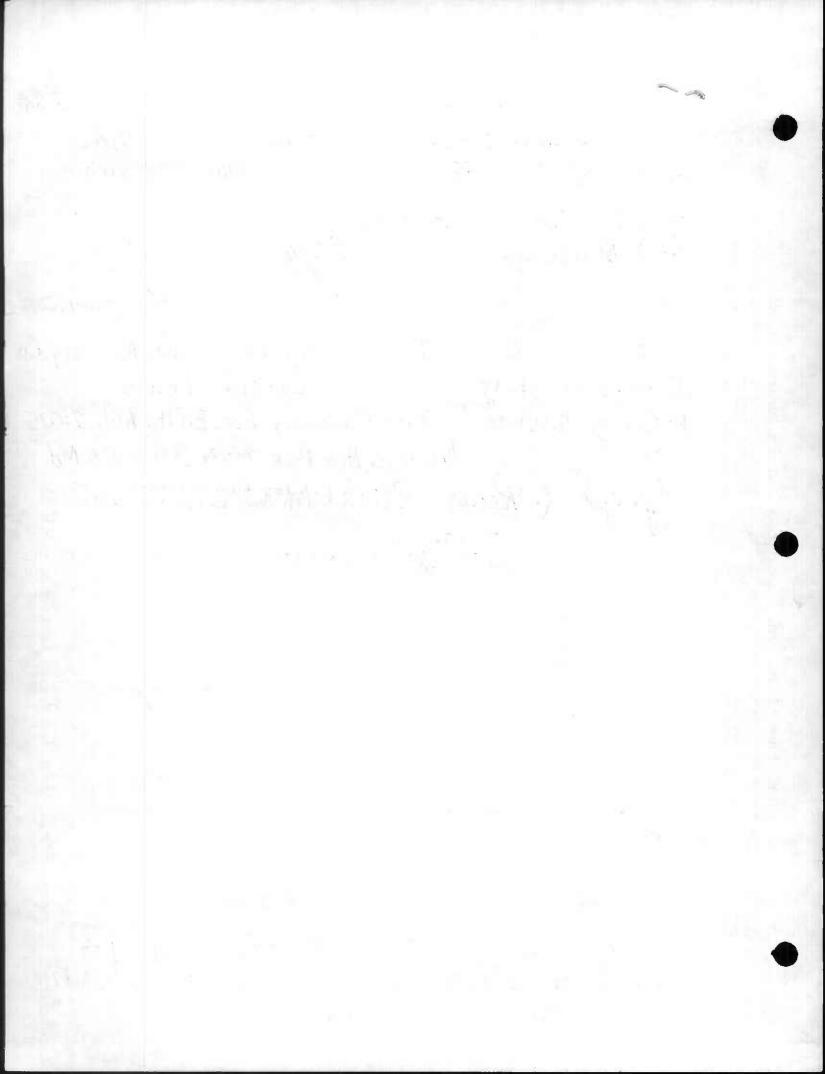
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State Registrar

31. Date thed (Month, Day, Year) FEB 23

32. Registrar's Signatura

1 Certifying Physician: To tha best of my knowladga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ITEMS: #7 PER F.H. G769 3-17-99 WR. Certificate of Death Red No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Vee Ames Feb. 1999 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 2000 W. BON BALLMORE St. SECOURS BALTO If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplace (Stete or Foreign Country) Months Days 110 M 2□ F Hours Min. Yrs. 59 60 215-34-9206 SEPT 7,1938 MARYLAND Usuel Residence of Decedent 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☑ Yes 2 ☐ No MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zlp Code 10g. Citizen of Whet Country? 1531 RAMSEY STREET 21223 U.S.A. 14. Race - American Indien, 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) MOUNTAIN SIDE TRANSP. 10TH GRADE TRUCK DRIVER 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) LOUIS WHITE REGINA KUHL 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) CATHERINE P. WHITE (WIFE) 1531 RAMSEY STREET - BALTIMORE, MARYLAND 21223 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Dete 1 ABurlel 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) LOUDON PARK CEMETERY 2/23/99 BALTIMORE, MARYLAND of Funegal Service Licenses 22. Name end Address of Facility HUBBARD FUNERAL HOME, INC. hans 4107 WILKENS AVENUE-BALTIMORE, MARYLAND 21223 23a. Pan Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, sharp or heert feilure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Final disease or condition (or es e consequença of): Varice Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieled events resulting in deeth) Lest Due to (or as a consequence of) 0 Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown 24b. Were eutopsy findings eveilable prior to 24e. Wes en autopsy completion of cause of deeth? 2 10 No 1 TYes 1 Yes 2 No 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 28b. Time of

physician end the bunal-transit the death certificate be axecuted P.O. Box 68760. 88 attending p for usa as signed by the a The law requires thet Division of Vital Records. been si certificate has t or Attending Physician: director, this funeral Aftert

Physician

/Medical

Examiner

Funeral

Director

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parmit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or Items 23a any Injury or other traumatic event, the Medical Expringer mans 200.00.

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25. Wes case referred to medical examiner? 1 Yes 2 No 27. Menner of Deeth 1 Neturel 5 Pending 2 ☐ Accident

3 ☐ Suicide

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4 Homicide

(Check only one)

investigation 6 Could not be determined 28a. Date of Injury (Month, Dey Year)

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated.

29b. Signeture

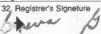
29c. License number D175

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Ham 23a) (Type, Print)

DARSHAN-S - SALUA MD 1600W MOUNT Royal Aug Galto -SALUJA MD 31. Dete filed (Month, Dey, Year)

State Registrar



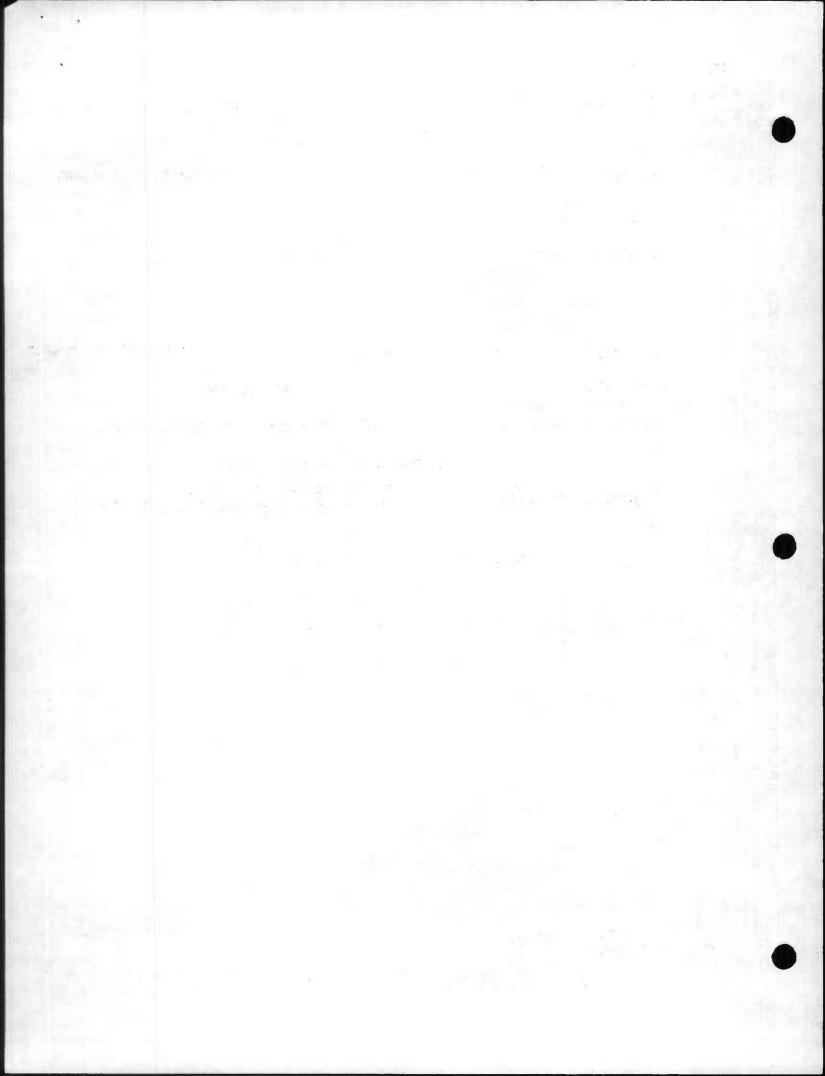
DHMH 16 Rev 6/95

n 24 hours efter death.

Funeral Director: Alphabaly filled in by the fu

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death.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Day Year Month 0150A1 MARIE A. WALTON 1999 Feb. 22 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death ST. AGNES HOSPITAL BALTIMORE If Under 24 Hrs. 8. Data of Birth Hours | Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) Days 1 M 2 XF Yrs. MAY 14,1903 212-07-7567 MARYLAND Usual Residence of Deceden 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yas 2 No MARYLAND BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1063 ELM ROAD 21227 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 6TH GRADE 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) CONRAD CHARLES WEIGMAN EMMA VIRGINIA HOFFMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) EDITH M. MATTINGLY (DAUGHTER) 1063 ELM ROAD - BALTIMORE, MARYLAND 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 2/25/99 LOUDON PARK CEMETERY BALTIMORE, MARYLAND 4 Donation 5 ☐ Other (Specify) 21. Signature of Funaral Sanfice Licensee HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MARYLAND 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death Immediata Causa (Final SUBDURAL diseasa or condition resulting in death) TROLL Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Ware autopsy findings available prior to completion of cause of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitat: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 1 Impatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yas 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide

Examiner Box 68760, Records. P.O. MARIE A. Division of Vital or Attending Physician: WALTON deeth. To the Hospital or within 24 hours eft. To the Funeral Dic completely filled in

Physician

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Director

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Certification: To

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29a. Certifier

(Check only one)

Funeral

Director

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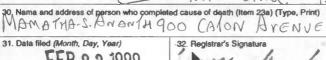
V

State Registrar

31. Data filed (Month, Day, Year)

Manatha S. Snanth

29b. Signature and title of certifier



ALLENDING

1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to tha cause(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at tha time, date and place, and due to the causa(s) and manner stated.

29c. License number

D0053439

BALLIMORE

29d. Date signed (Month. Day, Year)

MD21229

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State Registrar

filed (Month, Day, Year) FEB 2 3 1999

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Physician CARL E, ZAISER Fe6 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD COUNTY GENERAL HOSPITAL COLUMBIA If Under 24 Hrs. 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** 10 M 2 F Months Days Hours Min. Yrs. Director 88 220-05-9017 BALTIMORE, MD Usual Residence of Deceden or 28a-f show a notified at 10a Stata 10b. Counts 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Directo MARYLAND HOWARD ELLICOTT CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b Name 23a 9944 RT 108 21042 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 7 is marked other than "naturel", or iten traumatic event, the Medical Examiner Black, Whita, atc. 1 Xes 2 No If Yes, Give Year or Dates: WW II 72 hours after 1X Never Married 2□ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify:WHITE ğ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 Hyglene. other then "n Elementary/Secondary (0-12) College (1-4or 5+) ASSEMBLYMAN MANUFACTURING 12TH GRADE permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy important: If New 27 is marked other any injury or other traumatic event. 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be HERMAN ZAISER ANNA ROETLINGSCHOFFER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EVELYN Z. NOLAN (NIECE) 6024 JERRY'S DRIVE - COLUMBIA, MARYLAND 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 X Burial 2 Cremation 3 Removal Irom Stata 4 ☐ Donation 5 ☐ Other (Specify) LOUDON PARK CEMETERY 2/18/99 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MARYLAND 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disease or condition rasulting in death) Examiner Due to (or as a consequence of) Examiner physician and the burial-tranait Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably ▼ ☐ Unknown by 24b. Wara autopsy lindings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed 2 DNo 1 Yas 2 No 1 Yes Division of Vital 25. Was case referred to medicat examiner? Be 26. Placa of Death (Check only one) Hospital: 1 Timpatient 2 FP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To this After thi funeral 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural or Attanding after death. Director: Aft 1 Yas 2 No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, larm, street, lactory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in TE-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) 028998 Feb 16 1999

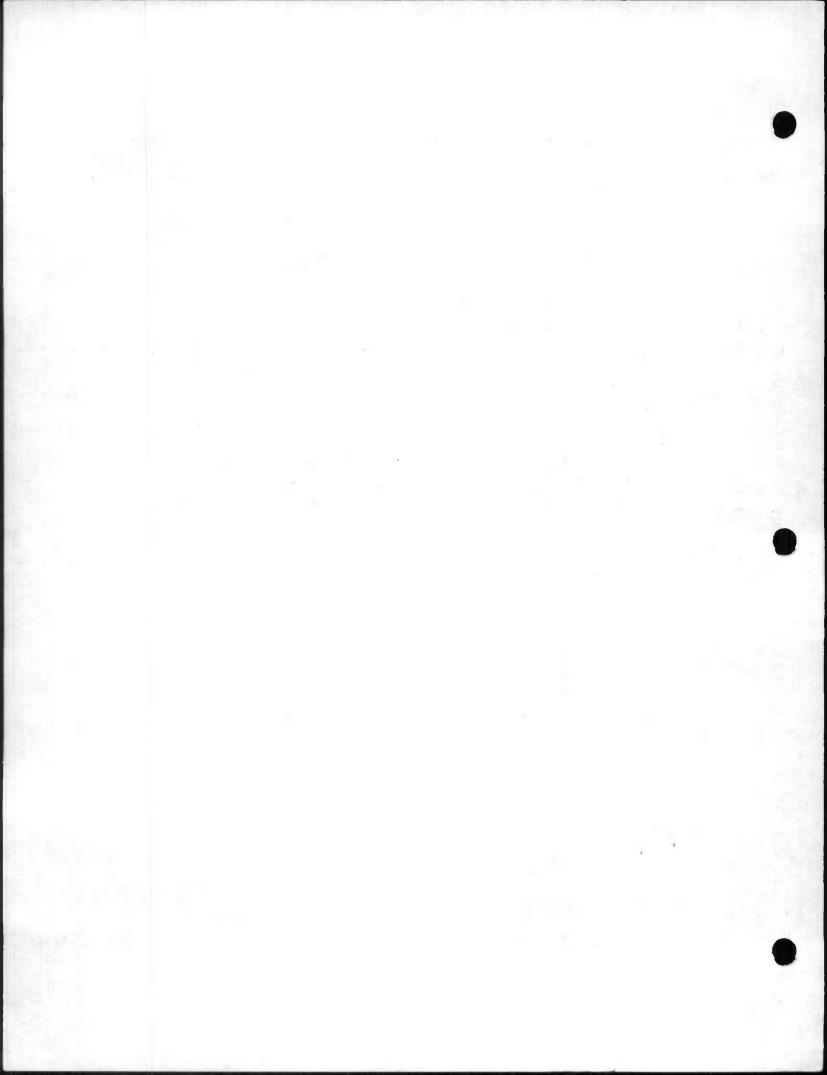
State Registrar 31. Data filed (Month, Day, Year)
FFR 9 3 1990

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RITAM FSAINI MD

(po. Prim) 9/0/ cherry 2N # 2/1/ Laurel MD 20708



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEbruary 13 1230/A 11ZAbeth HIZ011 4a Facility Nama (If not institution, giva straat and number, 4b. City, Town, or Location of Death 4c. County of Death MANOR Tue or many /an If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 7. Age (In yrs. lest birthday) Birthplace (Stata or Foreign Country) 5. Social Security Number 1 M 2 F Yrs. 217-12-7331 Aug. 26, 1923 Maryland Usual Rasidance of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 GYes 2 □ No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 243 West Medwick Garth 21228 United States 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Orlgin? (Specify Yas or No. If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - Amarican Indian, Biack, White, etc. 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Giva Year or Dates: 1 Navar Marriad 2K Married 1□ Yes 2□ No Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Spacify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher's Assistant Teaching 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) John Twilley Pearl Gambiel 19a. Informent's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Kenneth Gilbert Zoll/husband 243 West Medwick Garth, Baltimore, Md 21228 20b. Place of Disposition (Neme of cemetery, cremetory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Crametion 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 2/17/99 Baltimore, MD of Emeral Service Licerary 22. Name and Addrass of Facility Loudon Park Funeral Home, Baltimore, Maryland 21229 3620 Wilkens Avenue Part. Enter the disease, or complications that caused the deeth. Do not antar tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Polumen a q Immediete Ceuse (Finel disaase or condition resulting in death) asportion Due to (or as a consequence of): ALZ Heiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated available) B/ wing thet initieted events resulting in death) Last Dua to (or as a consequanca of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Course and as ley's reluni 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Was en autopsy performed? 1 ☐ Yes 2 No 1□ Yes PUNo 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death

Physician/Medical Examiner The law requires that the death certificate be executed P.O. Box 68760, Records, þ Completed certificate has birector, page 2 s Division of Vital Be To After this Certification: Hospital or Attending death. 24 hours

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

MD

Funeral

Director

7 is marked other than "natural", or feams 23a or 28a-f show traumstic event, the Wodical Examiner must be notified at

Peges 1 and 2 should be nent of Health and Mentel

Important: If Item 27 is any Injury or other traun

Physician

riviedical Examiner

Flizabeth

25. Was case referred to medical 1 Yas 2 No

> 1 Dilaturel
> 2 Accident 5 Pending Investigation 6 Could not be determined 3 ☐ Suicide 4 Homicide

28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

281. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

29b. Signatura and title of certifier

29a, Certifier

(Check only

edicai

604632

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Dete filed (Month, Dey, Yeer)

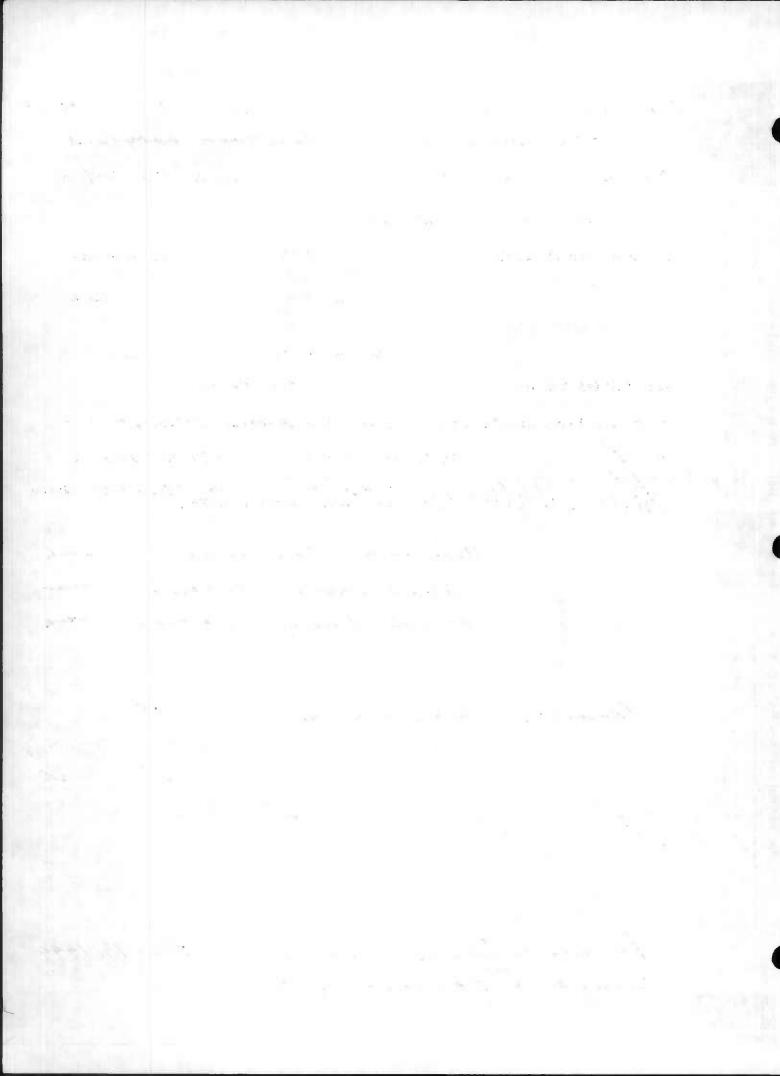
FEB 23

32. Pigistrar's Signeture

SABUNDAYS

Registrar

To the Hosp within 24 hor To the Fune completely fi



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ZEGAR FEBRUARY 14 1999 IRENE SOHN 7:42a 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth APRIL Day 13 1943 5. Social Security Number 6. Sex 9. Birthplaca (State or Foreign Days Min. Hours 107-34-4587 1 M 2 XF 55 Yrs. Months NEW YORK Usual Residence of Decedent 10e State 10c. City, Town or Location 10b. County 10d. Inside City Limits NEW YORK 1 Ves 2 No NEW YORK CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 111 WEST 89TH STREET 10024 U.S.A. 12. Wes Decedent Ever In U,S. Armed Forces? 1 Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 Never Married 2X Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kird of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) **PSYCHOTHERAPIST PSYCHOLOGY** 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) SOLOMON SOHN FREDIA WALK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES ZEGAR/HUSBAND 111 WEST 89TH STREET NEW YORK NY 10024 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 💆 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) MT. ARARAT CEMETERY 2/17/99 FARMINGDALE, NY 22. Name and Address of Facility 21. Signeture of Funeral Service Licensee SOL LEVINSON & BROS. 21208 8900 REISTERSTOWN ROAD PIKESVILLE MD 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Cause (Final diseese or condition resulting in death) HEART FAILURE 1 YEAR Due to (or as a consequenca of): DISEASE 1 SCHEMIC Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in death) Lest CORONARY ARTERI Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown LYMPHOMA 24b. Were eutopsy findings evellable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of 5 Pending 1 Yes 2 No Investigation

Examiner physicial and strangit Division of Vital Records, P.O. Box 68760, After this certificate hes funeral director, page 2: Hospital or Attending Physician: 24 hours after deeth.
 Funeral Director: After this certifical eleipt filled in by the funeral director. It Medical

Physician

/Medical

Examiner

NY

Director

Funeral

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Completed

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2

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Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

7 la marked other traumatic event,

5 = Department

Physician

/Medical

Examiner

Pages 1 end 2 should be filled within 72 hours efter death with the Meryland nant of Heelth and Mental Hygiene. At 11 flem 27 la marked other than "natural", or frams 23a or 28a-f show

Baltimore, Maryland 21215-0020

Physician/Medical by Completed Be Certification: To

To the Hosp within 24 ho To the Fune completely f

25. Was casa referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 Natural 2 Accident 3 Sulcide

6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

12 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and manner stated. (Check only one) 29b. Signature and this of certifier auszu

29c. License number RES-000 29d. Date signed (Month, Dey, Year)

30. Name and address of berson who completed cause of deeth (Item 23a) (Type, Print) SAWAN KAMAL

JOHNS HOPKINS HOSPITAL

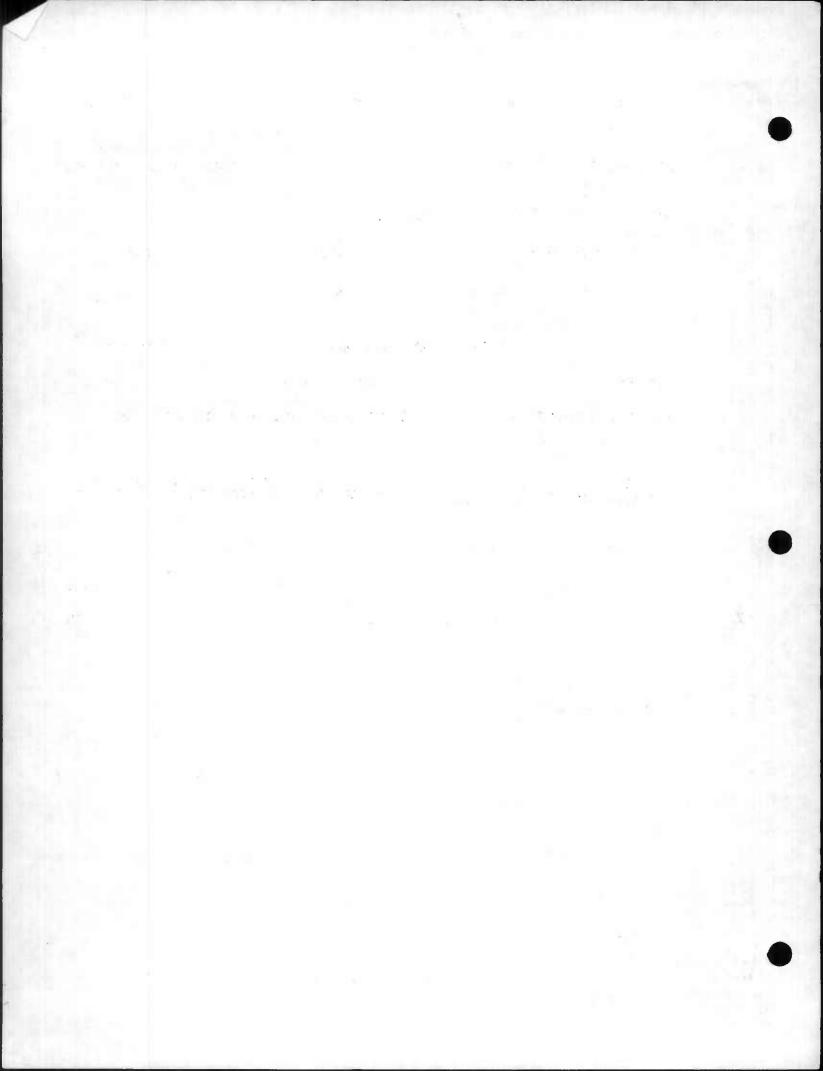
FEBREUARI

State Registrar

4 Homicide

29a. Certifier

32. Registrar's Signature



	1. De	ecedent's Name (First, Midd	lle, Last)			Cei	rtificat	e of	Death		2. Det	Re te of Deeth	g. No.		3. Tin	ne of Deeth
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Day RUTH ANDERSON FEBRUARY 8, 1999 eation of Deeth 4c. County of Death 1999 6:45 AM 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth WILSON HEALTH CARE CENTER GAITHERSBURG MONTGOMERY If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 1□M 297 F Months Days Yrs. 169 07 9258 84 DEC. 14.1914 PENNSYLVANIA Usual Residence of Decedent 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits MONTGOMERY GAITHERSBURG 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 8 RUSSELL AVENUE #302 20877 UNITED STATES 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ■ Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) RETAIL STORE 12 ACCOUNTING 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) CL YDF ANDERSON HAZEL. FFNNFLL. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) BETTIE J. POWERS, PERS. REP. 8 RUSSELL AVE., #302, GAITHERSBURG, MD. 20877 20b. Placa of Disposition (Neme of cemetery, cremetery or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 2/10/99 ALEXANDRIA, VA. 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heer tailure. List only one cause on each line. Approximate Interval Between Onset end Deeth Immediate Cause (Final disease or condition resulting In death) SC hemic bow Due to (or as a consequenca of). therosclausi) Veau Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Hiadeks Due to (or as e consequence of): 23h. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evallable prior to completion of cause of death? drieg k 24a. Was an autopsy performed? Cerebro varalas 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

the death certificate be executed

P.O. Box 68760

Division of Vital Records,

Physician

/Medical

Examiner

Funeral

Director

28a-f show

MD.

Director

Funeral

þ

Completed

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

permit. Peges 1 end 2 should be filed within 72 hours efter death v Department of Health end Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a any injury or other treumatic event, the Medical Examines must ence.

Saltimore, Maryland 21215-0020

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Examiner physician end the buriel-trans 89 950 for funerel director,

Physician/Medical by Completed Be

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Certification: To

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Director: After this certific

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Registrar

124 hours a

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of 5 Pending Investigation 1 Natural 2 Accident 1 Tes 2 No 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred et the time, date and pleca, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

GAI THEUTBURG

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN

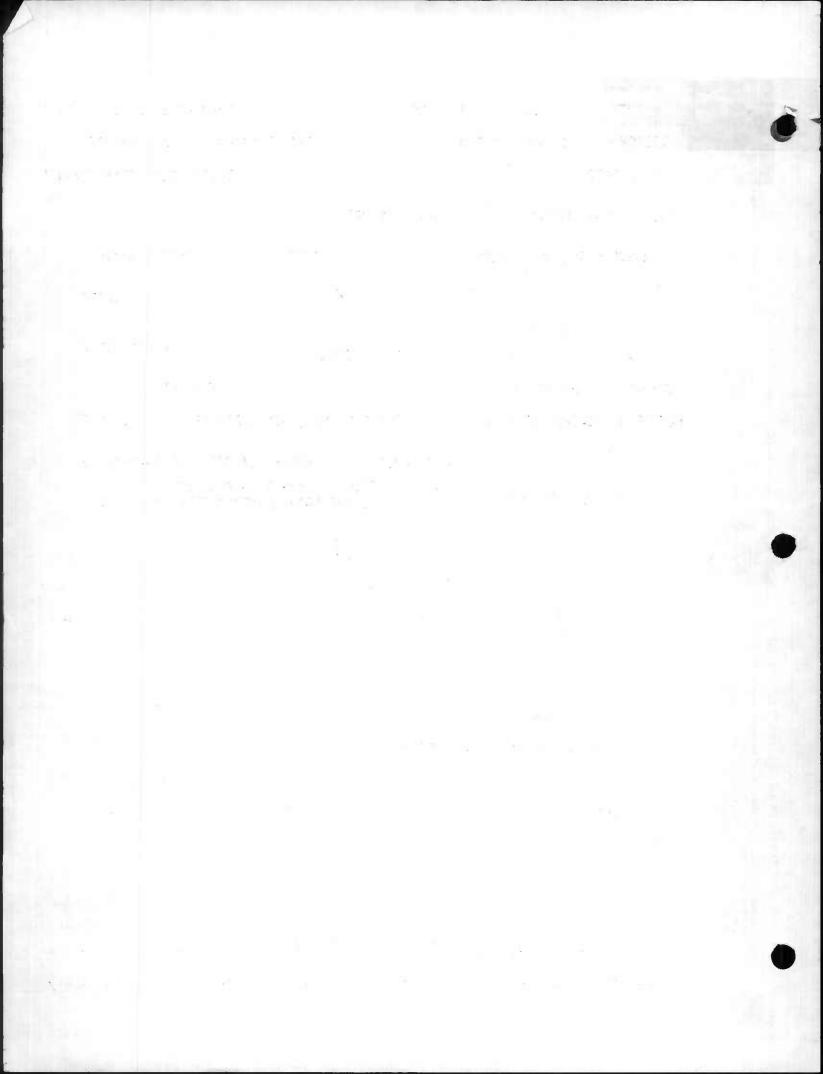
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31. Date filed Day, Year) EB 11 1999

29b. Signature and tifle of cartifier

32. Registrar's Signeture

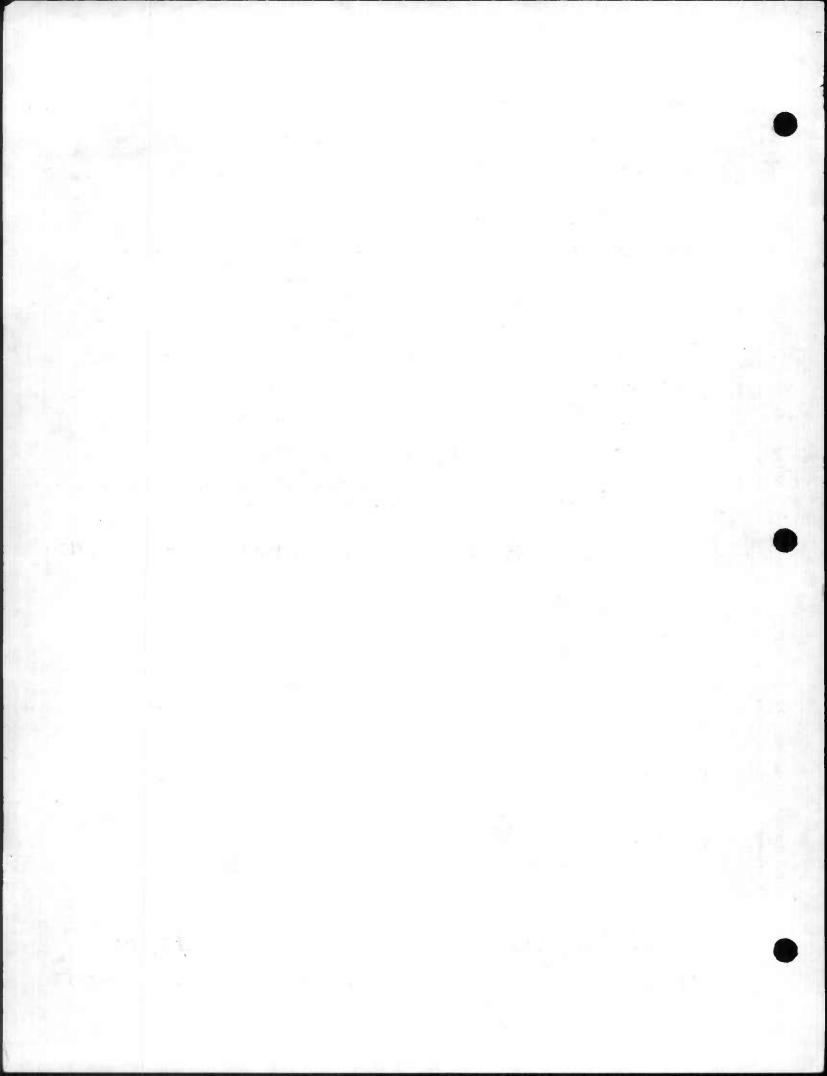
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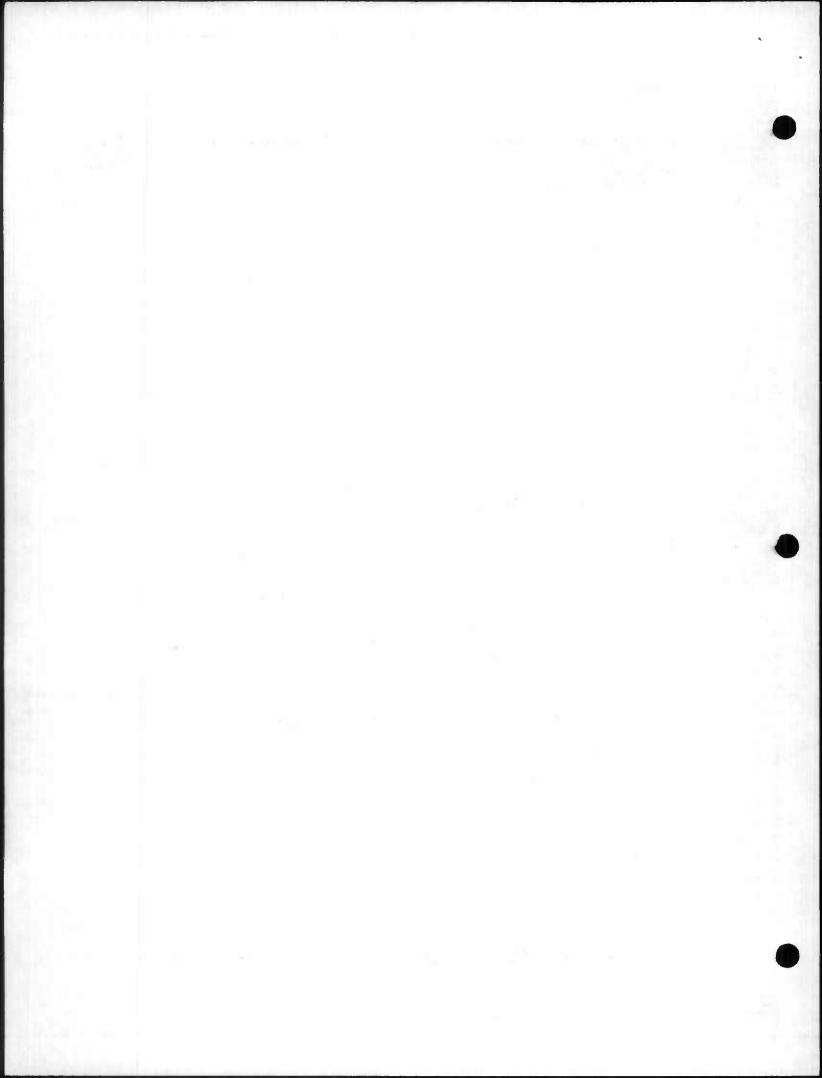
Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiane

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	Physicia /Medic	_	1. Decedent's Ner Epimenio			Arag	on						2. Date of D Month Februa	Day	Year 1999		of Death a.m.
	Examine		4a Facility Neme	(If not institutio	n, give s	treet and nu	ımber)					4b. City, Town, or		ith 4c. Co	ounty of Dea	th	
			Suburba		-					1 47 4 4		Bethesda			gomer		
	Funeral Director		5. Social Security 525–25–6	644	6. Sex	M 2□ F	7. Age 56	(in yrs.	last birthda Yrs.	Month	der 1 Year ns Days	If Under 24 Hrs Hours Min		irth Pay, Year) 1942		thplace (State ountry) W_Mex	ite or Foreign
	Du B		Usuel Residence	of Decedent 10b. County	,		1	10c. Cit	y, Town or	Location						10d. Insid	e City Limits
	28e-f show	ğ	MD	Montg	omer	У			hesda								Yes 2□No
	th with the Mi 23e or 28e-f	Funeral Director	10e. Street and No 8501 Ray		ad						Zip Code)817			_	n of What Co	ountry?	
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1474	n 72 houn "natural", soical Ex	To Be Completed		15. Deceder ecify only highe					(Gi	ve kind of	sual Occup work done Fuse retire	during most of wo	rking	16b. Kind	of Business	/Industry	
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, br	be filed htal Hygid of other event, II	9	17. Father's Neme	e (First, Middle,	Last)							18. Mother's Na	me (First, Middl	e, Maiden Su	ımame)		
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ga,	Page nent o int: if iry or			© Cremetion 5 ☐ Other (S		emovel from	State	Ba	emetery.c 1timo emato	re/Wa	shing	gton	2/9/99	Laure	1, Ma	ryland	đ
Aleagon, 2/3/99 C	permit. Pages 1 and 2 should be filed v Department of Heelth and Mental Hygie Important: If Item 27 Is marked other ten eny injury or other traumatic event, the page.		21. Signations of F	La Service	Licenso	3,				22. Name Josepi	and Addre	ler's So			Wisc	onsin	Avenue
AN.			23a. Part . Enter shock, of he	the disease, or failure. List	r complice only on	cations thet	caused ti each line	he deeti				ington, ng, such es cardia			1 7		mete Between and Death
-9	Physician /Medical Examiner		Immediate Cause disease or conditi resulting in deeth	ion	a	Ac	tut	er	myc	car	dia	linfa	rction			ıd	ay
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	deeth e atte	Sicia	Part II. Other sign	ificant condition	ons conf	tributing to d	eath but	not resi	ulting in the	underlyine	g cause gi	ven in Pert I.	23b. Di	d tobacco us	e contribut	e to the cau	ise of death?
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lono	ath. r: After thi	ation:	27. Manner of Dea 1 ☑Natural 2 ☐ Accident	5 Pendir investi	gation	28a. Dete (Mon	of Injury th, Day	Year)	28b. Time Injury		28ç. İnju Wo 1 □	ryat rk?]Yes 2 □ No	28d. Describe	how injury o	occurred		
Division	a or Atte	Sertific	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	not be nined	28e. Plece build	of Injur	y - At ho (Specif)	ome, ferm, y)	street, fect	tory, office		28f. Location City or T	(Street and I own, State)	Number or F	lural Route I	Vumber,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edical Certification:	29e, Certifier (Check only one)	1 Certifyin 2 Medical	ng Physi Examin	clan: To the er: On the b and man	asis of e	xaminal	wledge, de tion and/or	ath occurre investigati	ed et the ti	me, date and place opinion, death occ	e, end due to thurred et the time	e cause(s) er e, date end pl	nd menner a lace, end du	s steted. e to the cau	se(s)
	To the To the		29b. Signature and	d tigla of certifie	r	700				2	29c. Licens	se number		29d. Dete s	signed (Mon	th, Day, Yea	er)
	60		Ma	Allen	7	ma					D29.	229		2/3	199		
	V		30. Name and add			mpleted caus	se of dea	oth (Item	23a) (Typ	e, Print)	Are	+730	Chery (hase	MO 2	2081	
	State Registra	٠	31. Date filed (Mor	EB 0 8		32. F	legistrar Depe			1. de	park	2			(C		

DHMH 16 Rev 6/95



Shady Grove Adventist Hospital Rockville, MD M. Fundral Director Shady Grove Adventist Hospital Rockville, MD M. Social Security Number 031-14-5465 Sex 25 7.4 per (in yrs. last brinday) Fundral year Fundral 24 Sex 1.0 page 1.0	9. Birthplece (State or Foreign Country) BOSTON, MA 10d. Inside City Limits 1\(\tilde{\tile{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{
Shady Grove Adventist Hospital Rockville, MD M. Funeral Director Social Security Number S	9. Birthplece (State or Foreign Foundly) Boston, MA 10d. Inside City Limits 1\(\tilde{\text{D}}\) Yes 2\(\to \text{No}\) n of What Country? A Race - American Indian, Black, While, etc. secity: White of Business/Industry ineering meme) own, Stete, Zip Code) VD 20872 ioa - City or Town, Stete Day I a S.,
S. Social Security Number 031-14-5465 Usual Residence of Decedent 10a. State 10b. County Montgomery Montgomery Montgomery Montgomery Damascus 10c. City, Town or Location Damascus 10d. Zip Code 20872 11d. Merital Status 10d. Street and Number 10d. Specify Cuban, Mexican, Puerto Rican, etc.) Street or Dates 10d. Specify Cuban, Mexican, Puerto Rican, etc.) 11d. Merital Status 11d. Merital	9. Birthplece (State or Foreign Country) BOSTON, MA 10d. Inside City Limits 11 Yes 2 No n of What Country? A Race - American Indian, Black, While, etc. White of Business/Industry ineering meme) own, Stete, Zip Code) WD 20872 ioa - City or Town, Stete Day Town, Stete
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Physician Medical Examiner	MD 20872
Physician Medical Examiner	ion - City or Town, Stete
Physician Medical Examiner	Dallas,
Physician Medical Examiner	ling County, GA
Physician /Medical Examiner 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Immediate Cause (Finel disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as e consequence of): Due to (or as e consequence of): Due to (or as e consequence of): Due to (or as e consequence of): Due to (or as e consequence of):	3
Physician /Medical Examiner Immediate Cause (Finel disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	rgia 30132 Approximate Intervel Between
Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco us.	Onset and Death
0 6 5 5 8	e contribute to the cause of death?
<u>vi</u> : 5.8 [a]	No 3 Probably 4 Unknown 24b. Were autopsy findings
SPLODE NOTE OF THE PROPERTY OF	eveilable prior to completion of cause of death?
25. Was case referred to medical exeminer?	12103 2210
25. Was case referred to medical exeminer? 1	
Comparison Com	ccurred
S S S S S S S S S S S S S S S S S S S	lumber or Rural Route Number,
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29b. Signature end title of certifier 29c. License number 29d. Date s	
- 1 1 02/74	igned (Month, Dey, Year)
30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Gita C. Bakshi, M.D. 9406 Old Georgetown Road, Bethesda, Marylan	
State State Pagistrar State Pagistrar 31. Date filed (Month, Day, Year) 12. Registrer's Signature	ry 2, 1999



				Certificate of			Reg. No. 9 9	0.5	365
Physic	ian	Decedent's Neme (First, Middle, Las.	1)			2. Dete of De Month	eth Dey	Үөөг	3. Time of Death
/Medi		Ronald Busse				Februa		1999	2200
Exami		4e. Fecility Neme (If not institution, give Kent & Queen A	street end number) Anne's Hospital		4b. City, Town, or Lo Chestert	cation of Deeth		of Deeth	
Funeral Director	-	5. Sociel Security Number 6. Se 131–22–0121	7. Age (<i>In yrs. las</i> ŽM 2□ F	t birthday) if Under 1 Yea Months Deys	s Hours Min	8. Date of Bir (Month, Da May 4,	y Year)	9. Birthple Countr New Jo	ece (State or Foreign y) ersev
wo mend		Usuel Residence of Decedent 10a. Stete 10b. County	10c. City,	Town or Location					d. Inside City Limits
with the Marylend a or 28a-f show be notified at	tor	Maryland Kent	Ch	estertown					1 XYes 2 □ No
or 28	Director	10e. Street end Number		10f. Zip Code			10g. Citizen of V	Whet Counti	ry?
23a Lunt b	la	Heron Point Talbot Wi	ng	216	20		USA		
72 hours after death with the Maryland natural; or Items 23a or 28a-f show deat Example must be notified at	by Funeral	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Yeer or Detes:	13. Was Decedent of if Yes, specify Cu 1 ☐ Yes 2 ☑ No	Hispenic Origin? (Spi ben, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		e - America ck, White, et : White	tc.
within ene. then	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	College (1-40r 5+)	16e. Decedent's Usuel Occ. (Give kind of work don life. DO NOT use retir	upetion e during most of work ed)	ing	16b. Kind of Bu		
be filed ttal Hyg d other event,	BeC	17. Fether's Neme (First, Middle, Last)			18. Mother's Neme	(First, Middle,			041101116
S should be filed and Mental Hygi is marked other aumatic event,	TOE	William Charles He			Daisey An				
d 2 should th and Men 7 is marke traumatic		19e. Informent's Neme/Reletionship (T) Susan Broussard/ (1	19b. Meiling Address (Street					
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permit. Pages Department of Important: If it any Injury or of		21. Signature of Fyneral Service Licege	/ UES	apeake Cremation 22. Name end Add	ress of Fecility		Stevensv		D
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Physician /Medical Examiner	her	23a. Part1. Enter the disease, or conditions, or heart failure. List only of Immediate Ceuse (Final disease or condition resulting in deeth)		nuccialis s e consequenca of):					ntérvel Between Onset and Deeth
ficate be executed physician end s the buriel-transit	I Examiner	Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or Injury	Due to (or es	s e consequence of):					
* D #	n/Medical	resulting in death) Lest	Due to (or es	e consequence of):					
death cert e attending od for use	sicla	Pert II. Other eignificent conditione con	ntributing to death but not resulting	on in the underlying cause of	iven in Pert I	23h Did t	tobacco use cor	atribute to t	the cause of deeth
hat the rd by th deteche	by Physician/M		inibuting to death but not resulting	ig in the underlying cause g	iven in Pett I.	1 🗆			abiy 4 Unknow
aw requir is been s 2 should	Completed						en eutopsy rmed?	eveii	e eutopsy findings ieble prior to pletion of cause eeth?
The la	Co					101	res 2 No	10	Yes 2□ No
Physician: The rhis certificate oral director, peg	Be	25. Wes case referred to medical exeminer?	lospitel:	_ 0	26. Piece of Death				
i or Attending Physeleter death. Director: After this die by the funeral di	ation: To	27. Menner of Deeth 1 Neturel 5 Pending investigation	1 LInpatient 2 NER	b. Time of injury 28c. Injury	4 LI Nursing Hor		dence 6 Other		
To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, fectory, office		28f. Location (5 City or Tox	Street and Numb vn, State)	er or Rural I	Route Number,
To the Hospital within 24 hours To the Funeral completely filled	edical	29a. Certifier (Check only one) Certifying Phys	elicien: To the best of my knowled	dge, deeth occurred et the t end/or investigation, in my	ime, dete end plece, e opinion, deeth occurre	end due to the o	cause(s) end me dete end place, e	nner es ste end due to t	ted. he ceuse(s)
o the	Mec	29b. Signeture en title of certifier	and menner steted.		se number	-	29d. Date signed		
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	- 1	74000	1		, v - (- 3	1 1	
		30. Name end eddress of person who co	bleted cause of deeth (Item 23	le) (Type, Print)				-	-
		30. Name and address of person who co John C. Seymour, M 31. Date filed (Month, Day, Year)			Chesterto	vn, MD	21620		

and 30 Ell

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth **Physician** Month Sarah Eva Barrett 1999 February 6:55 p.m /Medical 4e. Fecility Name (If not institution, give street and numbar) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 21101 Iowa Avenue (Residence) Chestertown Kent | It Undar 24 Hrs. | 8. Date of Birth (Month, Dey, Yeer) | 9. Birthplace (Ste Country) | New Jersey If Undar 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Birthplace (Stete or Foraign Country) 1□ M 2 F Deys 139-14-9123 78 Yrs. Director Usual Residence of Decedent death with the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar mant be notified at 1 ☐ Yes 2 No Director Maryland Kent Chestertown 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21101 Iowa Avenue 21620 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Giva Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puarto Ricen, etc.) Race - Americen Indian, Bleck, White, atc. filed within 72 hours efter 1 Never Merried 2 Married 21215-0020 1 ☐ Yes 2 No Specify: by Specity: White 3 Widowed 4 Divorced Completed 15. Dacedent's Education (Specify only highest grada completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home permit. Peges 1 and 2 should be file.
Deperment of Health end Mental Hygi Important: If Item 27 Is merked eny Injury or other 27 Is merked once. 7 is marked other traumatic event, altimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Jesse Vandegrift Martha Sweeten 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Arlene G. Douglas/Daughter 21101 Iowa Avenue, Chestertown, MD 20b. Plece of Disposition (Name of cematery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burlel 2XX remetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Othar (Specify) Chesapeake Cremation Center, LLC 2/10/99 Stevensville, MD 22. Name and Address of Facility 21. Signeture of Fugleral Service Licens Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620 picop in the causad the death. Do not enter the mode of dying, such as cardiac or respiretory errast, one ceuse on each line. Approximete Intervel Batween Onset end Death **Physician** Immediete Ceuse (Final diseese or condition resulting In death) /Medical PATCHAMIL CATCON Examiner Examiner The law requires that the death certificete be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in death) Lest Due to (or es e consequence of): P.O. Box 68760, Physician/Medical Dua to (or as e consequance of) Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy certificete hes 1 Yes 2 No 1 ☐ Yas 2 ☐ No or Attending Physician: Be 25. Wes case referred to medicel axeminer? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify)

Injury et 28d. Describe how injury occurred 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury et Work? 27. Menner of Deeth Dete of Injury (Month, Dey Year) 28b. Time of Injury Certification: After 5 Pending investigation 1 Naturel deeth. 1 Yes efter deeth 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Steta) 4 Homicide • Funeral Certifying Phyeicien: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner stated. Medical 29a. Certifier (Check only within 2

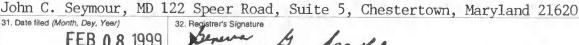
State Registrar

12

31. Date filed (Month, Day, Year) FEB 08 1999

30. Name end eooress of person who completed cause of deeth (Item 23a) (Type, Print)

29b. Signeture and title of certifier



29c. License number

17-13824

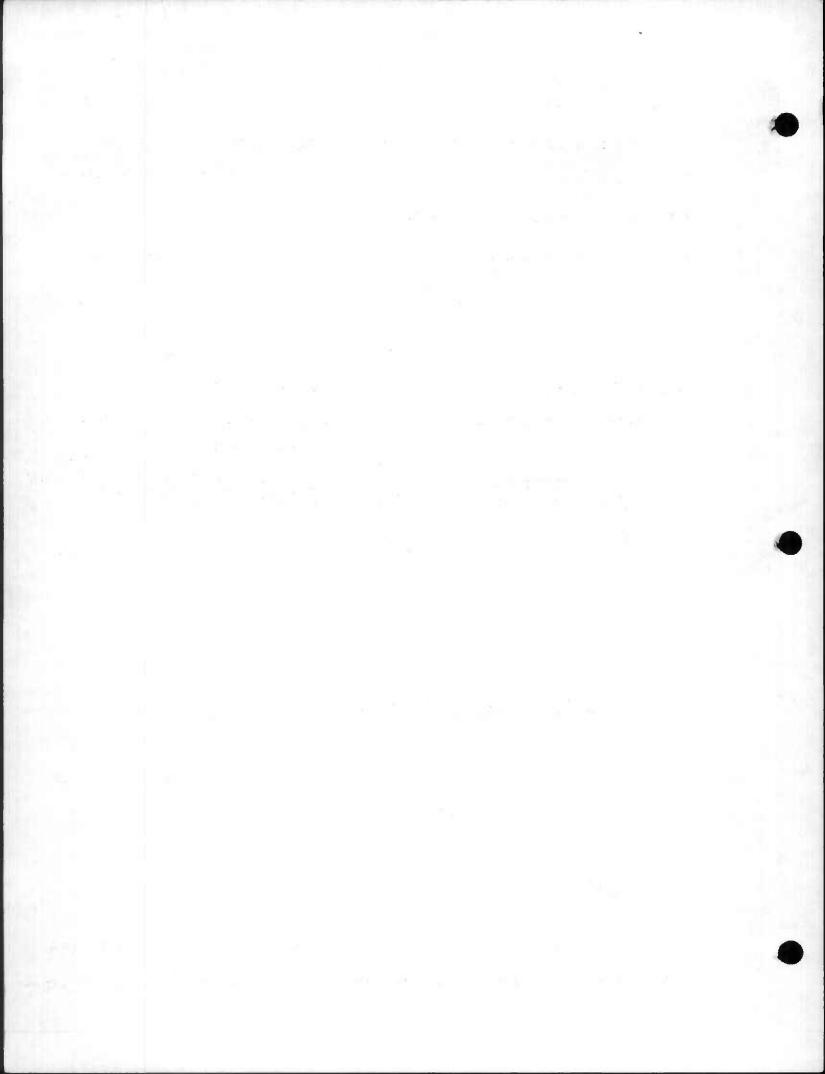
29d. Data signed (Month, Dey, Year)

CAR 8 0 833

State of Maryland / Department of Health and Mental Hygiene

						Cei	rtificate of	Death		Reg. No.	05367	
	Physici	an	1. Decedent's Name (First, Middle, La						2. Dete of Dee	eth	3. Time of Lea	#th
	/Medic		William A. Barne	S					Februar	ry 3, 19		I M
} I	Examir	ner	4e. Fecility Neme (If not institution, give	re street and number)				4b. City, Town, or L	ocation of Deeth	4c. County o	f Deeth	
			Shady Grove	Adventis	t Hos	pita	1	Rockvi If Under 24 Hrs.	lle	Mont	gomery	
	uneral rector			Sex 7. Ag	je (In yrs. lest 82	Yrs.	Months Deys	Hours Min.	(Month, De)	v, Year)	9. Birthplece <i>(S</i> tete or Fo Country) Pennsylvani	oreign .a.
Pue	2		Usuel Residence of Decedent 10a. Stete 10b. County		10c. City, To	oum or Lo	cation				40d Inside City	1
laryle	a pho	5	Maryland Montgom	erv		omac	Cation				10d. Inside City L	
the N	28a-f show	Director	10e. Street end Number			Omac	101 7in Code			40- 00		2110
with	9			11 Count			10f. Zip Code			10g. Citizen of Wi		
leath	rount E	era	11702 North Bunne	12. Wes Decedent	Ever in U.S.	13. \	20854		ecify Yes or No-	United 14 Bace	- American Indian,	
d 21215-0020 filed within 72 hours after death with the Maryland thygiene.	r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ⊠ Yes 2 ☐ If Yes, Give Yeer or Dates:	No Worl	d .	f Yes, specify Cul 1 ☐ Yes 2 No	Hispenic Origin? (Speen, Mexican, Puerto Specify:	Rican, etc.)	Bleck Specify:	White, etc.	
5-0 72 hc	hatri	eted	15. Decedent's Ed (Specify only highest gra	ducation	1:	6a. Deced	dent's Usuel Occu	petion	rina	16b. Kind of Bus	iness/Industry	
vithin within ene.	than the	Completed	Elementery/Secondary (0-12)	College (1-4or :	5+)			during most of worked)	any .			
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Aaryland 2 should be f end Mentei H	7 is marke traumatic	1º	Leonard E. Barne			01 1 1 1 1 1 1	- 1 1 1 2 2 2	Katherin				
2 00	- e		19a. Informent's Neme/Relationship (Mary Elizabeth Ba					t end Number or Rui unnell Co		-		
	item 27 other t	ŀ	20e. Method of Disposition	riies/ baagi				(e) February			City or Town, Stete	
			1 ☐ Burial 2 🖾 Cremetion 3 ☐									
Baltimo permit. Page Department	mportant: any injury once.		4 Donetion 5 Other (Special 21. Signature of Funeral Service Ober	0 1	Mont			torium, I			, Maryland Funeral Hor	ma /
8 88	any any		* XKAny /)		100680	Ro	ckville, Rockvil	Inc. 300 le, Maryl	West Mo and 2085	ontgomer; 50-2805	y Avenue,	me /
	sician		23a. Part I Ently the driebse, or com shock for hear value. List only	plications thet caused one ceuse on each li	the death. D	o not ente	er the mode of dy	lng, such es cardiac	or respiretory er	rest,	Approximete intervel Betwee Onset end Dee	en eth
	edical miner		Immediate Suse (Final disease or condition resulting in death)	a		101					years	
			resulting in dealth)		Due to (or es	e conseq	uence of):					
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Sord Taguir	pinous	Completed							24a. Wes		24b. Were eutopsy findi eveileble prior to completion of caus of deeth?	
Z 2	ate has	E O							1 D Y	as 20 No	1 ☐ Yes 2 ☐ No	
	certificate rector, pag	Be C	25. Wes case referred to medical					26. Plece of Deal				
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DIVISION i or Attending efter deeth.	irect n by	Ě	3 Sulcide 6 Could not b 4 Homicide determined		ury - At home, c. (Specify)	ferm, stre	eet, fectory, office		28f. Location (S City or Tow	Street end Number m, Stete)	or Rurel Route Number,	
Urs el	iled i											
DIVISION To the Hospital or Attending	Fund tely f	edical	29e. Certifier (Check only one) 1 ☐ Certifying Ph 2 ☐ Medical Exam	ysician: To the best of ninar: On the basis of	examinetion	lge, death end/or inv	occurred et the trestigetion, in my	ime, dete end plece, opinion, deeth occur	end due to the d red et the time, d	euse(s) end men date end place, er	ner es steted. id due to the cause(s)	
the the	o the	Med	29b. Signeture end title of certifier	end menner sta	ated.			se number			(Month, Dey, Year)	
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15	1'	-	20 Name and address of severe)	looth (tr c-	-) (T :	7	(0)	, u	enhour	07,1799	
,			30. Name and eddress of person who	ai McGu	reivy	990	() () -	cal Cente	n pund	tode	Ille MD Za	350
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DHMH 16 Rev 6/95



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HICHE	1 11200,	-	Decedent's Name (First, Middle)				Ortinoato or	Doutil	2. Date of Dea	ith	3. Time of Death
	Physicia /Madia		Ire	ne Kate Be	erti				February	5, 19	Yeer 99 12:01 A.M.
	/Medica		4a Facility Name (If not institution	n, give street and nu	mber)			4b. City, Town, or Lo	ocation of Death	4c. County of	of Death
			Washington Ad		-			akoma Par		Montgo	
	Funeral Director		5. Sociel Security Number 408-34-8643	6. Sex 1 □ M 2 🗓 F	7. Age (in yrs. 74	ast birthda Yrs	Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, De) Dec. 7,	/ Voor)	9. Birthplace (State or Foreign Country) Virginia
70	8 m	-	Usual Residence of Decedent 10e. State 10b. County		10c. City	, Town or	Location				10d. inside City Limits
Social of the stock	4.5	to	Maryland Montgo	omery	Roc	kvil:	le				1MYes 2□No
4	2 28 erroll	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of W	hat Country?
4	23	2	5712 Ridgway A				20851			United :	
d	or its	by Funeral	11. Maritel Status 1 □ Never Married 2 ☑ Mar 3 □ Widowed 4 □ Divorcac	ried 1 ☐ Yes	2 💢 No	S. 1	 Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No 		ecify Yes or No- Rican, etc.)	Black	- American Indian, c, White, etc. White
8	*natural',			nt's Education	retes.	18a. De	cedent's Usual Occup	pation		16b. Kind of Bu	siness/Industry
Maryland 21215-0020	- 6	Completed	(Specify only higher Elementary/Secondary (0-12)	st grede completed) College ((G	ive kind of work done o. DO NOT use retire	during most of work	ring		
213	giene.	E OC	12	College	1-40/01/		Manager			Gift	
pui	a oth	Be	17. Father's Name (First, Middle,					18. Mother's Nam			
ryla	Men Men Men Men Men Men Men Men Men Men	၉	Robert Taylor			105 14	- W 0 4d /Ot 4	Edna Eli			
Ma	th end		19a. Informant's Name/Relations Joseph A. Ber		d		2 Pidgray				yland 20851
ē, š	item 27 other tr	-	20a. Method of Disposition	c1/ Husball	OOL D	lane of Di	annoition /hlama of		D-4-		City or Town, State
Ou	00-		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State Gat	e of	Heaven Ce	emetery	2 9 00	Silver S	pring, Maryland
Baltimore,	Department Important: I any injury o	1	21, Signature of Funeral Service				22. Name and Addre	ess of Facility			
(0)	GEES		1 Kanto	for	M001	98	Robert A. Pu 300 West Mor	mpnrey rune ntgomerv Ave	eral Home,	kville. M	aryland 20850-2805
	hysiclan		23a. Part1. Enter the disease, o shock, or heart allure. List	r complications that t only one cause on							Approximate Interval Between Onset and Death
	/Medical		Immediate Cause (Final disease or condition	CA	PNING	25	IC SH	LACY			Houpe
E	xaminer		resulting in death)	a			sequence of):	ULE			110000
7	e it	xaminer		- Her	TRT F	AIL	URE				DAVS
50,	8 W	iii	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	MIT	·	0	sequence of):	706U			DAYS
876	physic the t	dica	that initiated events resulting In death) Last		Due to (o	es e con	uR617AT sequence of):				
9 X	ding ise es	Me		d. My	OCARD	TAL	INFA	RCTION			DAYS
a g	etten 1 for u	clar	Dort II. Other elemificant conditi	and contributing to	looth but not roo	ulting in th	o undodvina couco ni	uon la Part i	23h Did	obacco use cor	atribute to the cause of death?
0	by the	hys	Part II. Other eignificent conditi	-1/2 - 118-7-1					40	Yes 2 No	3 □ Probably 4 🖔 Unknown
R. 2	gned I	S P	POST OPER	ATIVE !	VITEAL	VAL	VE REP	LACEMEN	7		
Division of Vital Records, P.O. Box 68760,	s been signal	Be Completed by Physician/Medical	AND CO	RONARY	Byp	ASS			24a. Wes perfo	en eutopsy med?	24b. Were autopsy findings available prior to completion of cause of death?
Re	te her	E							101	res 210 No	1 ☐ Yes 2 ☐ No
ital	ctor, p	Be C	25. Was case referred to medica	N				26. Plece of Dea	th (Check only o	ne)	
of V	l direc	2	examiner? 1 Yes 2 No			ER/Outpa	Itient 3LI DOA			denca 6 □Oth	
vision of Vita	veth. w: After the	ation:	Z LJ Accident	igation	of Injury oth, Day Year)	28b. Tim Inju	ry Wo	ryet irk?]Yes 2 □ No		now injury occurr	
Divis	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending physician completely filled in by the funeral director, page 2 should be deteched for use as the bune	edical Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 28e. Plac build	a of Injury - At he ling, etc. (Specif	ome, farm,	, street, factory, offica		28f. Location (S City or Tov	Street end Numb vn, Stete)	er or Rural Route Number,
1	Euner Funer letely fill	dical	29a. Certifier 1 Certifying (Check only one)	Examiner: On the b	e best of my kno pasis of examina oner stated.	wledge, delion and/o	eath occurred et the ti r Investigation, in my	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and me date and placa,	nner as steted. and due to the cause(s)
	들들은	¥ E	29b. Signature and title of certific	er			29c. Licen	se number		29d. Date signed	1 (Month, Day, Year)
5	S T K		1 Thomas	1 4						-	RY 5, 1999

State Registrar

31. Date filed (Month, Day, Year) FEB 0 9 1999

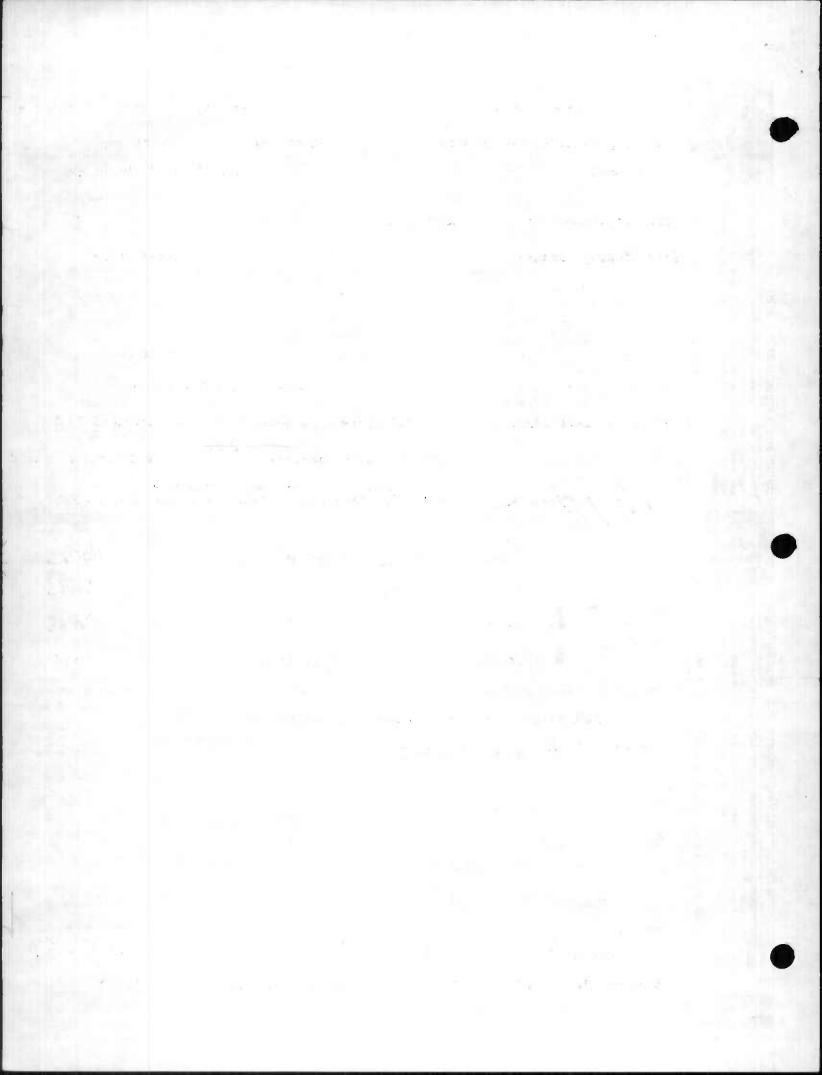
Thomas Mitilano, M.D.

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

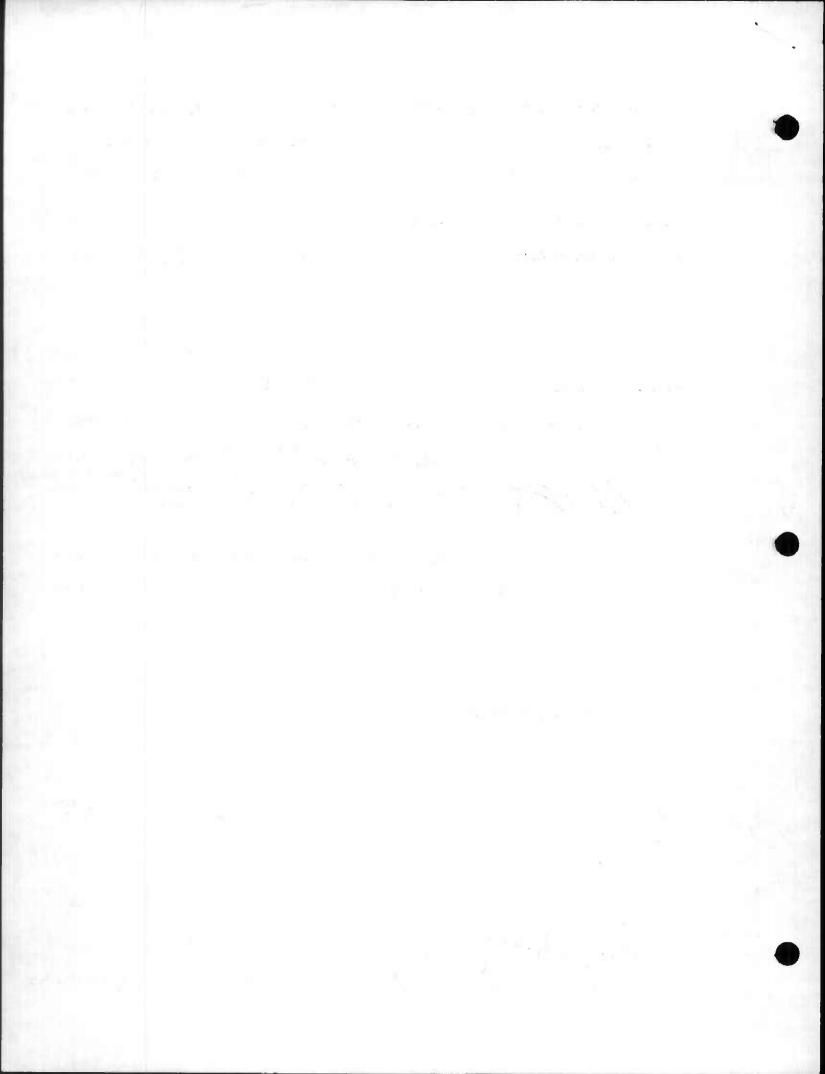
32. Registrar's Signature

7610 Carroll Avenue, Takoma Park, Maryland 20913

D36207



end #4a,2	2/:	19/99,BMW,Montg Co					Health and f Death	Mental Hy	rgiene Reg. No. 🔘 🔾	0.5	269
Physician	١	1. Dacedant's Nama (First, Middla, La Rose Williams Bla		AKA E	aster	Rose Bl	lackburn	2. Date of Da Month Februa	Day	Year	3. Time of Death
/Medical Examiner	_	le. Fecility Nama (If not institution, giv Haven Havan Assisted Li)			4b. City, Town, or	Location of Deal	h 4c. County		
Funeral Director		5. Social Sacurity Number 6. S 578-03-6373		ga (In yrs. le 89	ast birthday) Yrs.	If Undar 1 Yas Months Day	or If Undar 24 Hrs	8. Date of Bi		9. Birthplace Country)	
with the Maryland a or 28a-f show Lbs.notified at Director	ľ	Usual Rasidanca of Dacadant 10a. Stata Maryland Howard			Town or Lo						Insida City Lim
with the Ma a or 28a-f s be notified		10e. Street and Number				10f. Zip Coda	21771		10g. Citizan of		
was after death with the Maryla all, or items 23e or 28e-f ahoo Exernities must be notified at by Funeral Director		1850 Long Corner 11. Marital Status 1 □ Navar Married 2 □ Marriad 3 □ Widowed 4 ☑ Divorcad	12. Was Dacedant Armed Forces' 1 ☐ Yas 2 ☑ If Yas, Giva Yaar or Datas:	?		Vas Dacadant of Yas, specify Cu	f Hispanic Origin? (Suban, Maxican, Puar	Specify Yas or Noto Rican, atc.)		d State ce - Amarican i ck, Whita, atc. Whi	Indien,
Glock within 72 hours after thousanter that "natural", or its not, the Medical Examina ort, the Medical Examina or Completed by Fu		15. Decedant's Ec (Spacify only highast gra Elamentary/Sacondary (0-12)	Jucation	5+)	(Giva	OO NOT usa rati	red)	rking		usiness/Indust	try
B evelope	0	8 17. Fethar's Nama <i>(First, Middle, Last)</i> Gaston Owen Willi				Owne	18. Mother's Na	ma (First, Middle	Retail , Maidan Surman		Store
Health I Health I hem 27 is		19a. Informant's Name/Ralationship (Margaret B. Dugan 20a. Mathod of Disposition	/Daughter	20b. Pli	1710	Sunrise	Drive, R Maca) February	ockville		and 208	854
permit. Pages Department of Important: If Its any injury or o once.		1 X Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of Funeral Section 1)	y)	Ce d	lar Hi	11 Cemet Nama and Add ockville	rass of Facility Ro	bert A. 300 West	Montgo	y Fune	ral Hor
Physician /Medical Examiner	- 1	23a. Part 1. Proposed Sease, or com- shock, or heart failure. List buy. Immediate Ceusa (Final disaasa or condition rasulting in death)		ld_Dep	. Do not ente	er the mode of d	e, Marylan ying, such es cardia	c or raspiratory	errast,	Int Or	pproximete larvel Batwaan nsat and Death Cears
ntificete be executed ng physician and ses the bunal-transit		Sequentielly list conditions, if any, leading to immadiata cause. Enter Underlying Ceusa (Disease or Injury that initiated events resulting in death) Last	b. Chroni	Dua to (or		is uenca of):				Y	lears
the the death certific ed by the attending p detached for use es Physician/Mee) Sicial	Part II. Other algnificant conditions of			Iting in the ur	ndarlying causa	givan in Part I.		tobacco usa co		
been signer should be d	5	Hypertension, Hy	pothyrote	IISM	_			24a. Was	s en autopsy ormad?	24b. Ware availal	autopsy finding ble prior to letion of causa
ilcien: The law certificate hes rector, page 2									Yes 2⊠No		es 2□ No
ter this merel di	2	25. Was case rafarrad to medical axeminar? 1			ER/Outpetien 28b. Tima of Injury	28c. in	Other: 4 Nursing I		ona) idanca 6 ☑Ott how injury occur	ner (Specify)	ssisted iving
5 4 5 E		3 ☐ Suicida 6 ☐ Could not be datarminad	28a. Placa of In	jury - At hor tc. (Spacify)	ne, farm, str	aat, factory, offic	а		(Straat and Num wn, Steta)	ber or Rural Ro	outa Numbar,
To the Hospital or At within 24 hours effer or To the Funeral Direct completely filled in by Medical Certiff		29a. Certifiar 1 ☐ Cartifying Ph (Check only one) 2 ☑ Madical Exam	ysician: To the best niner: On the basis of end mannar st	of examineti	riadga, daath on and/or inv	occurred at tha astigation, in my	time, dete end place opinion, deeth occ	e, end due to the urred et the time	ceuse(s) and m , date end plece,	enner es stete end due to the	d. e cause(s)
		29b Signatura and little of certifier	1	- n	4	29c. Lica	nsa number		29d. Data signed		
10		90. Name and address of person who PATRUE A. TO		1 -	1	Print) eulod	e Conel	Jan &	tels 4	Cot MI	0 2104
State Registrar		FEB 0 9 19	32. Ragist	rar's Signati	J.	Spar	K)			



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death Day Month **Physician** Isabella T. Blancodine February 5, 1999 9:02 AM /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery f Under 24 Hrs 5. Social Security Number 7. Aga (In vrs. last birthday) If Under 1 Yaar 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Days Min. Months 1□M 2XF Hours 205-03-9064 Director 78 August 7, 1920 Pennsylvania Usual Residence of Decedent the Maryland 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yas 2 No Director Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Name 23a 11705 Tifton Drive 20854 United States Funeral 14. Race - Amarican Indian Black, Whita, etc. 12. Was Decedent Evar in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Status 72 hours after 1 ☐ Yas 2 ☒ No If Yas, Giva Yeer or Detes: 1 Never Married 2 Namied Baltimore, Maryland 21215-0020 'natural', or 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry fled within 7 Hyglene. other then "n Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Skin Care Salon permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If Item 27 is marked other any injury or other traumatic event, I 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Anthony Hodorowski Anna Smiegelski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas E. Blancodine/Husband 11705 Tifton Drive, Potomac, Maryland 20854 20b. Plece of Disposition (Nama of cemetary, crematory or other place) February 9, 1999 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from Stata
4 Donation 5 Dother (Specify) Entombment Gate of Heaven Mausoleum Rockville, Maryland 22. Nama and Address of Facility
Robert A. Pumphrey Funeral Home/Rockvile, Inc.
300 West Montgomery Avenue, Rockville, Maryland 20850—2805 Ours loal on but caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast, in cause on each line. 23a. Part V Enter the disease shock, or heart failure. Approximata Intarval Batween Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical PNEUMONIA Examiner Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): physician and s the burisi-tran Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, ğ 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to Completed completion of cause of death? 1 ☐ Yas 2 ☐ No 25. Was case refarred to medicat axaminer? 8 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yes 2 No 2 1 inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28b Tima of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: Natural 5 Pending 1 ☐ Yas 2 ☐ No death. 2 Accident invastigation 6 ☐ Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide ì 6 Certifying Physician: To tha best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and menner stated. 29a, Certifier edical (Check only one) 3% Within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and titla of certified 076259 30. Name and address of person who completed cadsa of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

Ava F. Kaufman, M.D.,

FEB 09

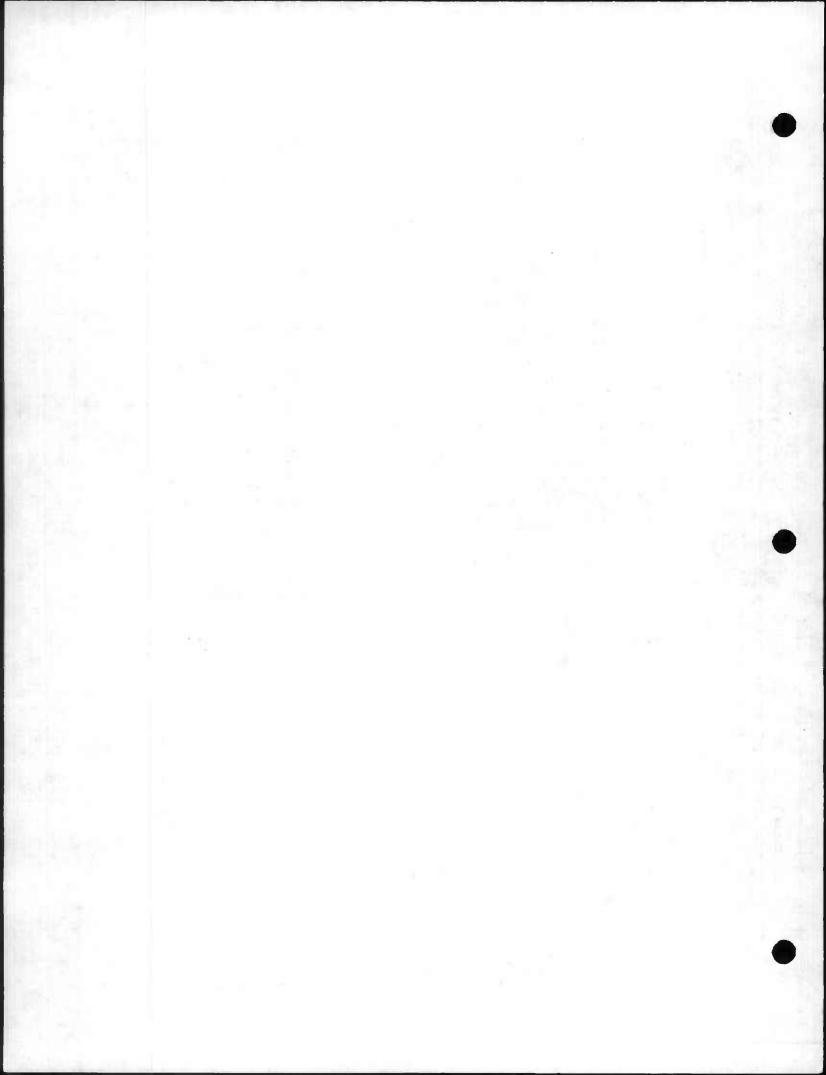
1999

31. Date filed (Month, Day, Year)

Ancodine, Isabella Tial 51

32. Registrar's Signatura

4903 Del Ray Avenue #403, Bethesda, Maryland



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1850 BLOCH DONALD M. FEBRUARY 06, 1999 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, giva street end number) Examiner PRINCE GEORGES REGIONAL HOSPITAL LAUREL LAUREL If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) Days 100 M 2□ F Months 577-10-0163 85 April 16, 1913 New Jersey Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. inside City Limits 1 ☐ Yes 2 X No Directo Maryland Montgomery Burtonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20866 United States Funeral 14601 Dowling Drive 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - Amarican Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2Ñ No Specify Specify: p 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpenter Construction 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be John Bloch. Nellie Stout 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. fnformant's Name/Relationship (Type, Print) (wife) Helen I. Bloch 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-9-99 Chesapeake Crematory Belstville, Maryland 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Rapp Funeral Services, P. A. 23a. Part1. Enter the disaasa, or compilcations that daused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. 933 Gist Avenue, Silver Spring, MD Approximata tnterval Between Onset and Death HYPERTENSIVE ARTERIOSCIERDTIU CARDIDVASCULAR DISETASE Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, teading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yes 2 No by 24b. Were autopsy tindings available prior to 24a. Was an autopsy Completed completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) 18 Yes 2□ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 30 DOA 1 ☐ Inpatient 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Dey Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 SNatural 5 Pending 1 ☐ Yes 2 ☐ No Investigation

physician and s the burial-transit the death certificete be executed Division of Vital Records, P.O. Box 68760 attending pt for use es t signed by the a rectificate has b After this funeral

Hospital or Attending Physician: 24 hours after death. after deat Director:

Funeral

Director

Pages 1 and 2 should be filed within 72 hours aftar death with the Manyland neaf of Health and Mental Hygiena. wit! If them 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, in a Mentical Examiner man be notified at my or other traumatic event, in a Mentical Examiner man be notified at

permit. Page Department of Important: If any injury or once.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

To the Hospital or within 24 hours aft To the Funeral Di completely filled in 6

> State Registrar

Medical

2 Accident

3 ☐ Sulcide

29a. Certifier

4 Homicide

(Check only one)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and menner es steled.

Medical Examiner: On the basis of examination and/on investigation, in my opinion, death occurred at the time, date end plece, and due to the cause(s) end manner stated. 29b. Signature and title of certile

6 Could not be determined

28e. Piace of Injury - At home, farm, street, fectory, office building, etc. (Specify)

29c. License number

29d. Date signed (Month, Dev. Year)

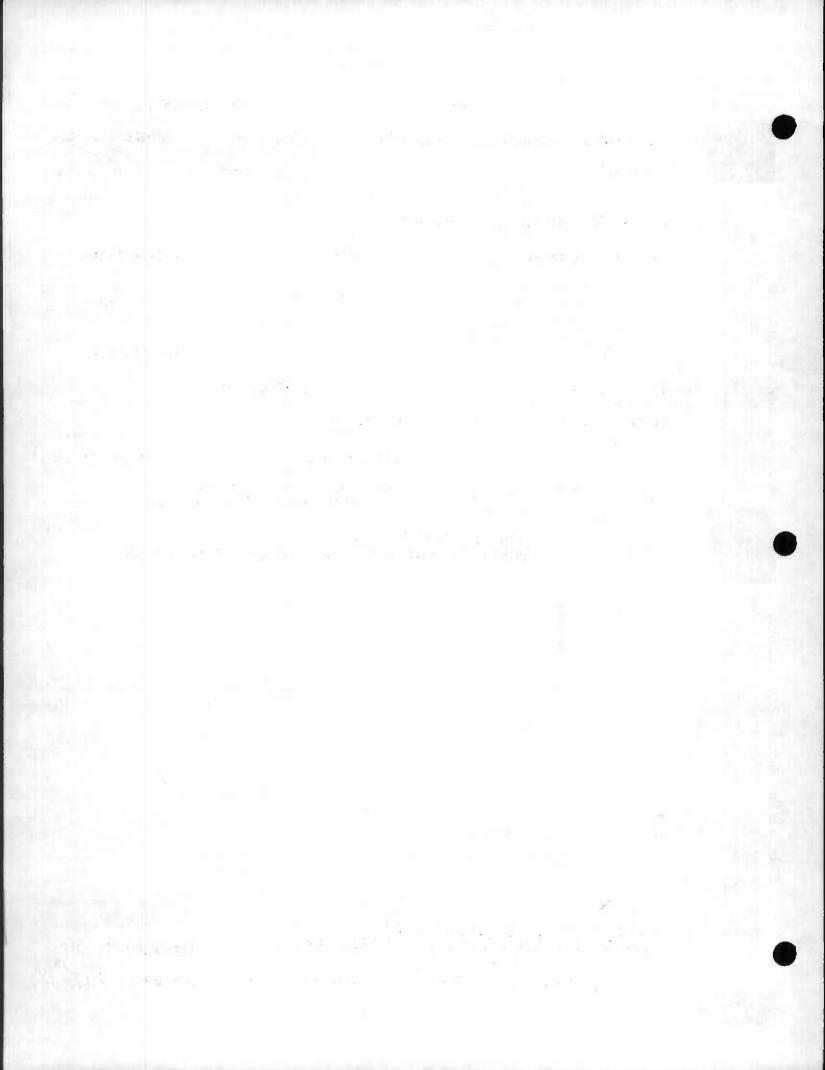
DRIVE CHEVERLY

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

d cay'se of death (Item 23a)/(Type, Print) 3001 HOSP

MARIO 31. Dete filed (Month. 32. Registrar's Signature

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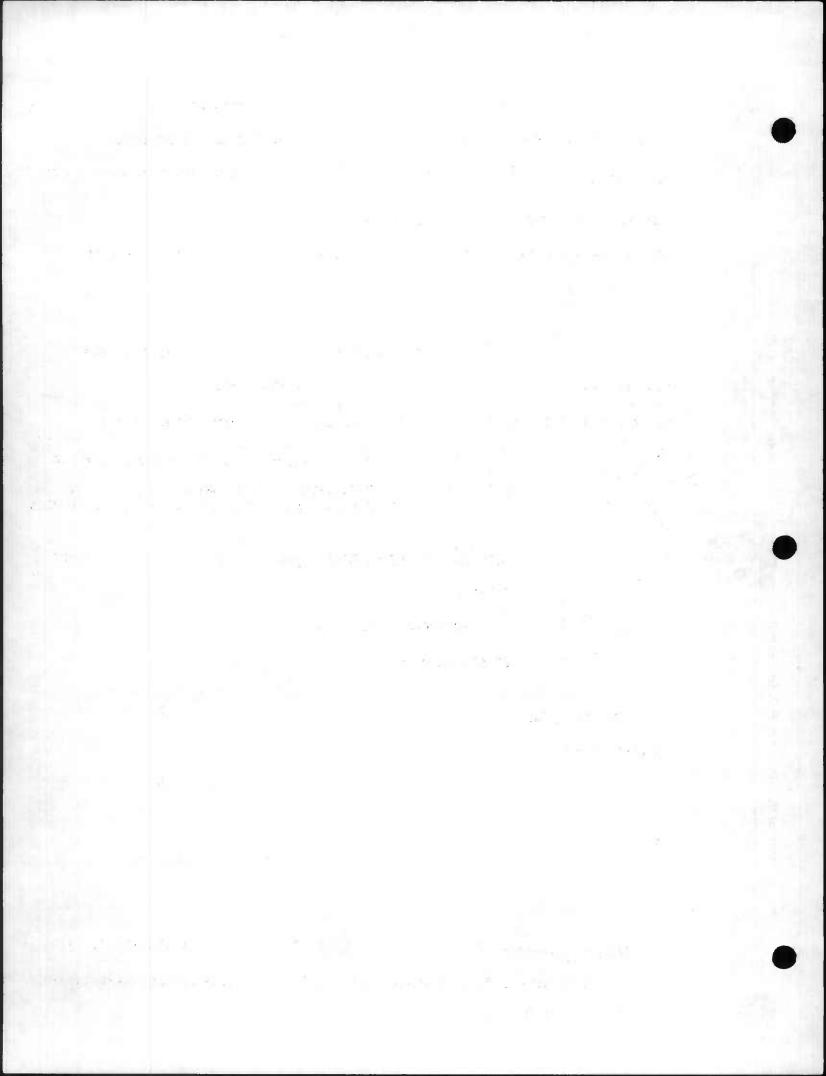


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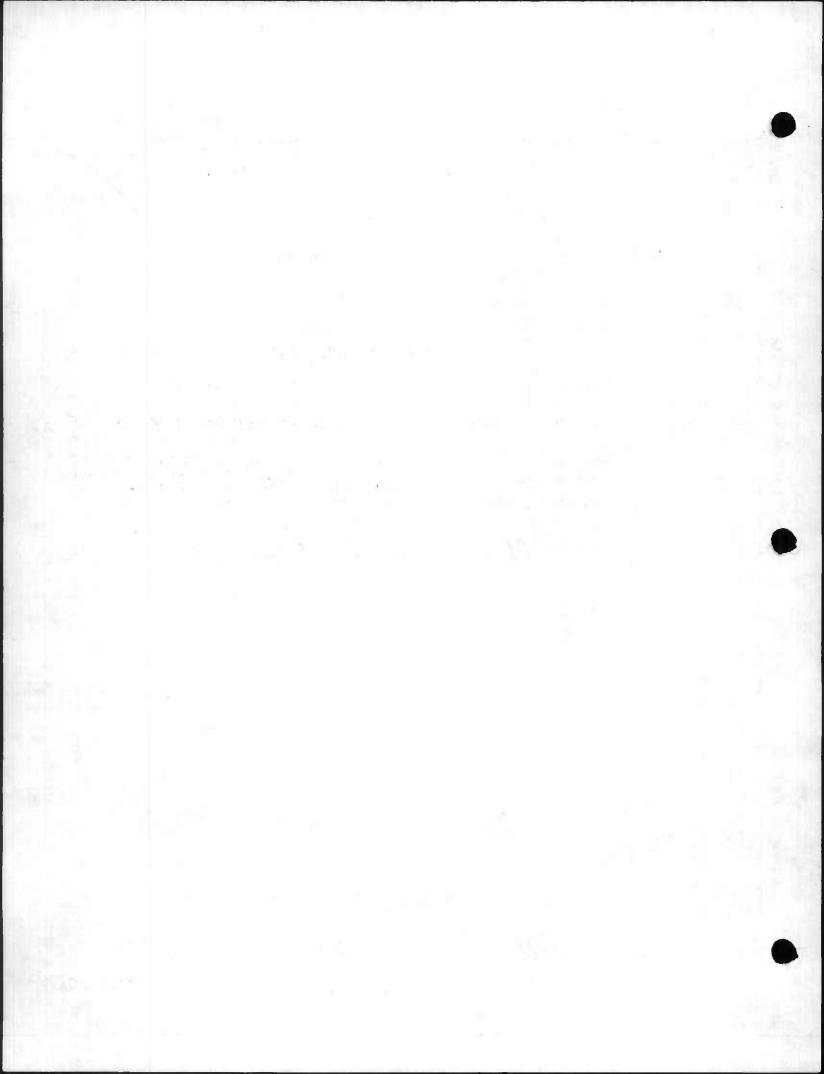
Decedent's Nama (First, Middle, La SARAH a Facility Nama (If not institution, gine 15100 INTERLACH) Social Security Number 6. \$ 5.77. 22 48.32 sual Residence of Decedent Os. State 10b. County MARYLAND MONTGO Os. Street and Number 1.5100 INTERLACHE 1. Marital Status	BLUM The street and number EN DRIVE TO M 2017	#510 Age (In yrs. I	last birthday)		4b. City, Town,	2. Dete of Month FEBRU or Location of D	JARY 10,	Yeer 1999 unty of Deeth	3. Tima of Death 9:00 AM
15100 INTERLACH Social Security Number 6. S 5.77 22 4832 Isual Residence of Decedent 0s. State 10b. County MARYLAND MONTGO 0s. Street and Number 15100 INTERLACHE	EN DRIVE OM 2NF 7.	#510 Age (In yrs. I				r Location of D	eath 4c. Co	unty of Deeth	
Social Security Number 6. 5	Sex 7.	Age (In yrs. i			OTT TIED	CDDTMC	1(0)	•	37
577 22 4832	DM 2⊠F	7		If Under 1 Ya	SILVER			TGOMER	
Os. State 10b. County MARYLAND MONTGO Os. Street and Number 15100 INTERLACHE	MERY	100 Ch	ev men	Months Da		n. SEPT	Birth Day, Year) 30,192	2 WASI	placa (State or Foreign ntry) HINGTON, DC
0e. Street and Number 15100 INTERLACHE	MERY	100. 089	y, Town or Lo	cation			100	- 1	10d. Inside City Limits
0e. Street and Number 15100 INTERLACHE	A.L.	177	STOCKED CONTRACTOR	SPRING					1 Ves 2□No
15100 INTERLACHE			THAME	10f. Zip Cod	io		10g. Citizen	of What Cou	ntry?
	DRIVE #	510		209				D STAT	
	12. Was Decede	nt Ever in U.	S. 13. V	150.50	of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes o		Race - Americ	can Indian,
1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Date	No No	9	Yes, specify (erto Ricen, etc.		Black, White, ecity: WH	
15, Decedent's E	ducation		16a. Deced	ient's Usual Oc	ocupation	- 33	16b, Kind	of Business/In	dustry
(Specify only highest gr	ede completed)	w Kal	(Give	kind of work do DO NOT use re	one during most of v tired)	ranking	1 - 11		
12	Compa (1-4	a 44)	SELF	EMPLOY	ED		PRIN	TING S	HOP
)					27		mame)	
9a. Informant's Name/Relationship	Type, Print)		19b. Mailin	g Address (St	reet and Number or	Aural Route N	umber, City or To	own, State, Zij	o Code)
RICHARD BLUMBER	G (SON)		3632	PINEHU	RST COURT	-PLANO,	TEXAS	75075	
			face of Dispor	sition (Name o	place)	Date	20c. Locat	ion - City or T	own, State
1 Burial 2 ☐ Cremation 24 4 ☐ Donation 5 ☐ Other (Speci	Removal from Sta	10				2/12/9	9 OLN	EY, MA	RYLAND
mmediate Cause (Final liseuse or condition southing in death)	a CORO	NARY A	ARTERY or as a conseq EROSIS	DISEAS		ac or respirato	ry arrest,		Approximate Interval Between Onset and Death YEARS
Sequentially list conditions, rany, leading to immediate		Due to (or	r as a conseq	uence of):				- 1	
Cause (Disease or injury	c OLD				ION			- 1	
esulting in death) Last		an involve	epolite i	uence of):				1	
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			28b. Time of	28c.	Injury at Work?	28d Desc	ribe how injury o	ocurred	
2 Accident investigation	n	370000	11,41,50						
3 Suicide 6 Could not to determined	286. P1808 0f			eet, factory, of	lice	28f. Locati City o	on (Street and A r Town, State)	lumber or Au	ral Route Number,
	niner: On the basis	of examinat							
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State Registrar

Sparks



			Cer	tificate of	Dealli			Reg. No.		
Decedent's Nama (First, Middla, Last	st)						2. Data of De Month	Day	Year	3. Time of Death
Jane M. Booth					41 O'T T-		Februa		999	7:26 AM
4a Facility Nama (If not institution, give Holy Cross Hosp:		er)					Carria o			
5. Social Sacurity Number 6. So		Ana (In urs	last birthday)	If Under 1 Year			Spring		tgome	L y blace (Stata or Foreign
	□M 2⊠F	86	Yrs.	Months Days	Hours	Min,	8. Data of Bir (Month, Da Aug. 25	1912	Cour	land
Usual Rasidence of Decedant		,					0-	, , , , , ,		
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MD Montgor	mery	Si	lver Sp							1 ☐ Yas 2 ☐ No
10e. Streat and Number				10f. Zip Code				10g. Citizen of		ntry?
510 Bonifant St		nt Ever in 11	C 12 W	Ves Doordont of I	2091		naife Van or No		USA ce - Americ	ean Indian
11. Marital Status 1 □ Nevar Marriad 2 □ Married	12. Was Deceder Armed Forcas 1 Yas 2	s?	,S. 13. W	Vas Decedent of I Yas, specify Cub	pen, Mexicar	n, Puerto	Rican, etc.)	Bia	ck, Whita,	
3 ☑ Widowed 4 ☐ Divorced	If Yas, Giva Yaar or Datas		1	☐ Yas 2 No	Specify:			Specif	y: W	hite
15. Decedent's Ed	lucation		16a. Decede	ent's Usual Occu	pation			16b. Kind of B		
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17. Fathar's Nama (First, Middla, Last)								, Maiden Suman	ma)	
Roy L. Sterling					1		G. Ray			
19a. Informant's Name/Ralationship (7		,		g Address (Stree						Code)
William I. Bootl	h (sc	-		larke La		eath	Data Data	VA ZZ	473	State Cure
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4 Donation 5 Other (Specify		For		oln Ceme		4		Brentwo		
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State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year February 4, 1999 **Physician** 2245 Brandon Rosetta /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Lorien Nursing Home Columbia Howard 5. Social Security Number if Undar 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1 M 2 34F Months Days Hours 56 Director 238-70-9601 May 6, 1942 NC Usuel Rasidence of Decedent with the Maryland th end Mentel Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show traumstic event, the Medical Examiner must be notified at 10e State 10h County 10c. City. Town or Location 10d. Insida City Limits DC NA Washington NE Yas 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 752 Morton Street, N. W. 20010 United States Funeral death 14. Race - American Indian, Black, Whita, atc. 12. Was Dacedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Yeer or Detas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 3€ No Specify: Specify: Black g 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grede completed) Collega (1-4or 5+) Elementery/Secondary (0-12) Home Maker Private 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) . Peges 1 and 2 should be file ment of Health end Mentel Hy lant: If Itam 27 Is marked oth Walley Stokes Myrtle Stokes 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Streat end Number or Rurel Route Number, City or Town, Stete, Zip Code) Otha L. Brandon - Husband 752 Morton Street, N.W., Washington, DC 20010 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Dete permit. Peges Department of Important: If It any Injury or o 1 Burial 2 Cramation 3 Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Glenwood Cemetery 2/11/99 Washington, DC 22. Name and Address of Facility R. N. Horton Co. Morticians, Inc. 21. Signature of Funeral Service Licansee 7-furth 600 Kennedy Street, N.W., Washingotn, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heert failure. List only one cause on each line. Approximata tnterval Between Onsat and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner that the death certificate be axecuted sician and burial-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the Due to (or as e consequence of) 88 950 6 signed by the a Part II. Other significant conditions contributing to deeth but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causs of death? 1 Yss 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to Completed 24a. Was en eutopsy performed? peed completion of cause of deeth? has 20 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Hospitel: 1 Yes No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpetient 3 DOA this 28a. Dete of Injury (Month, Dey Year) funeral 27. Manner of Death 28d. Describe how injury occurrad 28b. Time of 28c. Injury at Work? Certification: After 1 Naturel 2 Accident or Attending 5 Pending after death. 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28f. Location (Straet and Number or Rural Routa Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 24 hours a Hospital Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) end menner es steled.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end manner stated. 29a. Certifier Medical (Check only one) To the l within 2 To the f 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 41618 d cause of deeth (Item 23a) (Type, Print) 30. Name end eddress of person Rd Columbia Md 2100

Hickory Ridge

10805

32. Registrar's Signature

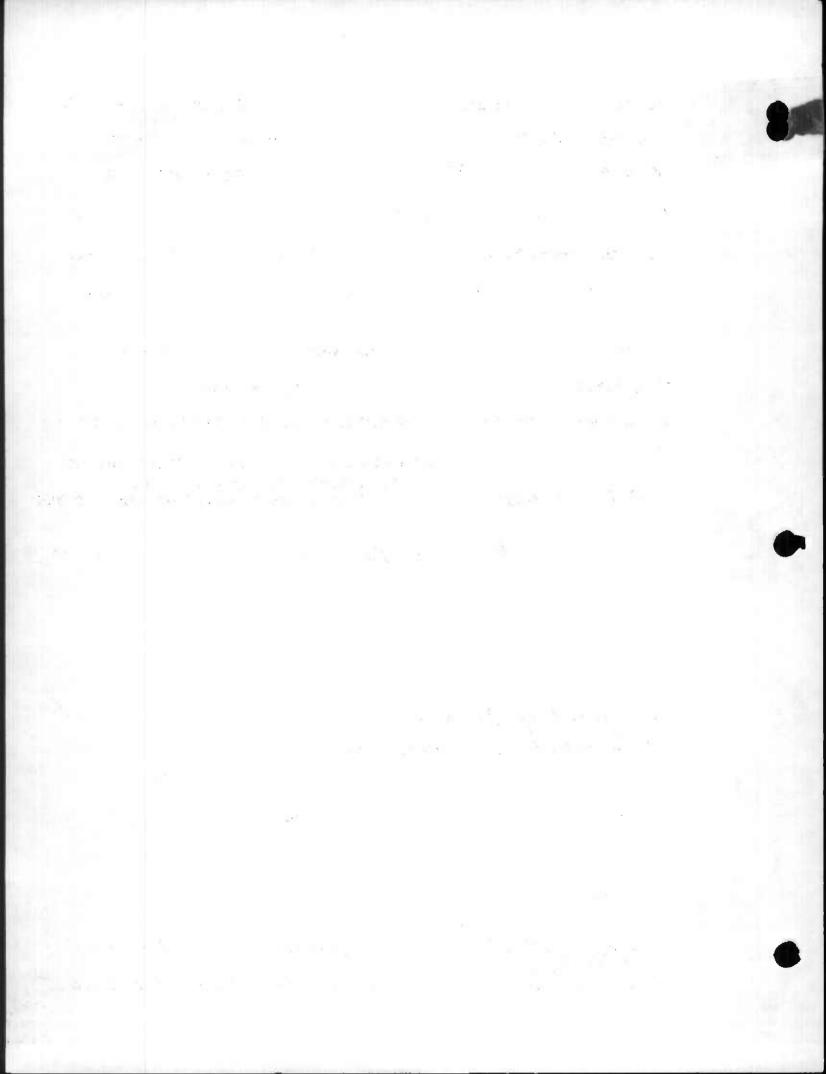
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31. Date filed (Month, Day, Year)

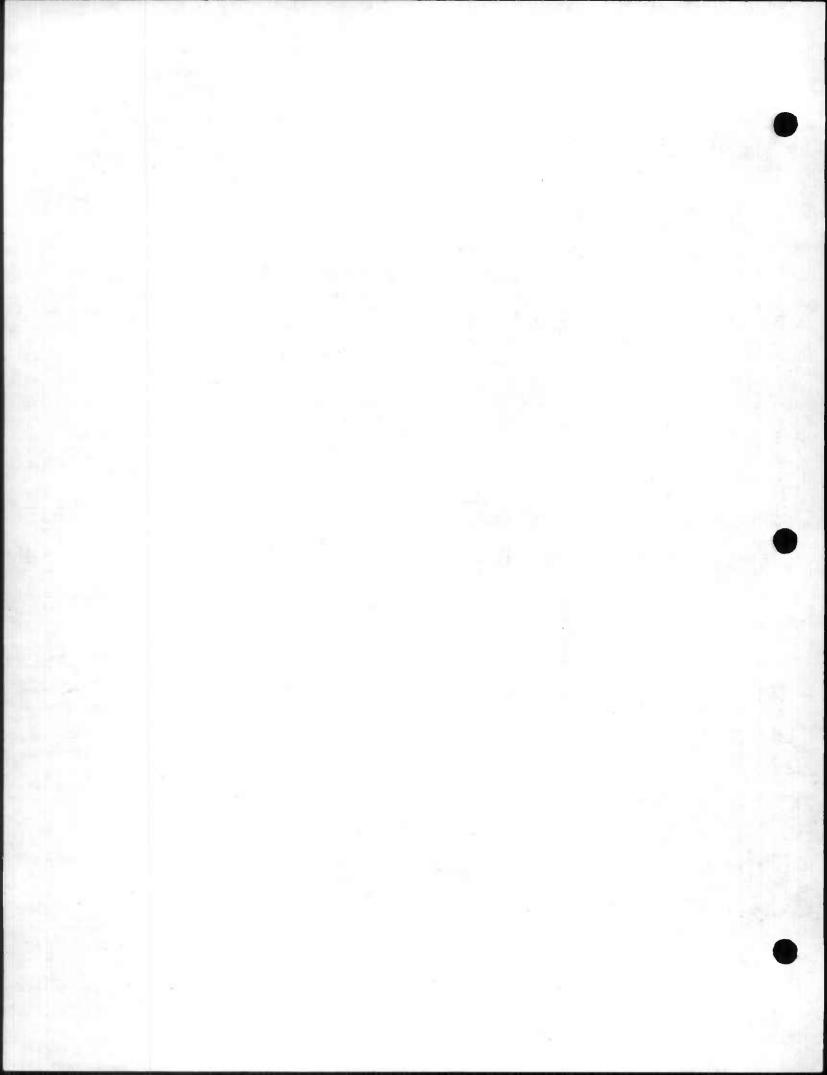
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State Registrar



State of Maryland / Department of Health and Mental Hygiene 99 05375

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11. M 11. M 11 3	Street and Number 99 Rollins Aven Aarital Status			kville	e				1 Yas
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	Informant's Name/Ralationship (tanton Brown	(son)				erand Number or F rrace, Si			20902
1	Mathod of Disposition 1 □ Burlal 2 ☑ Cramation 3 □ 4 □ Donation 5 □ Other (Specif			of Disposition by, cramator, opolita		ematory	Data 2/11/99		City or Town, Stata ria, Virgi
	Part Enter the disease or comparion, or heer failure. List only	Inion	tha daath. Do	Home	, Inc. er Spr	. 500 Un	iversity 20901	Blvd. W	s Funeral est Approximate Intervel Betwonset end Co
disae	ediata Causa (Final esa or condition iting in daath)	. My	OCON(Dua to (or as a	dial	/h-	Parct	on		unkne
Sequif any caus Ceus	uentially list conditions, y, laading to immedieta se. Enter Undarrying se (Diseese or injury	c	Dua to (or as a	consequence	e of):				
resui	initiated evants iting in death) Last	d	Dua to (or as a	consequence	e of):				
Pert	II. Other significant conditions of	ontributing to death be	it not resulting in	in the underly	vino causa o	iven in Part I.	23b. Díd	tobacco use con	tribute to the cause o
							10	Yes 2□ No	3 Probably 40
_								an autopsy ormed?	24b. Were autopsy fi available prior to completion of co of death?
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25. W	Vas casa retarred to medical					26. Placa of D	eath (Check only	, ,	
1	xaminar?	Hospital:	nt 2 ER/O	utpatient 30	X DOA O	ther		dence 6 □Othe	or (Specify)
6	lannar of Death	28a. Data of Inju	y 28b.	Tima of Injury	28c. Inje	ury at	28d. Describe	how injury occurre	ed
2 3	Natural Accidant Suicida Homicide Suicida	1	ıry - At homa, fa	М	1[Yes 2□No		Street and Numbe wn, Stata)	er or Rural Route Num
29a.		ysician: To the best on niner: On tha basis of and mannar sta	examination en						nnar as stated. nd dua to the cause(s
	Signature and title of certifier	L. Toms	ko, 4	mD	29c. Licer	D5/9/	6	29d. Date signed Febru	(Month, Day, Year) Any 7,/
Pa	lama and addrass of person who	nsko, MD	eath (Item 23a)	(Type, Print)	ockri	ille Pik	e,#34	8, Rock	ville, MD:



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3 Time of Deeth Month **Physician** Jane Betsy Burton February 8, 1999 6:45 PM /Medicai 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Mariner Health Care - Silver Spring Silver Spring Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | 9. Birthplece (State (Month, Day, Year) | 9. Birthplece (State (Month, Day, Year) | 1928 | Virginia 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funerai** 1 □ M 2 🕱 F Months 70 Yrs. Director 579-34-4234 Usuel Residence of Decaden the Meryland 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No MD Montgomery Silver Spring 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò 11402 Wheaton Hills Drive 238 20902 IISA Funeral death Herns 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: 1 Never Married 2 ☐ Married ò 1 Yes 2 No Specify: Specify: White g 3 Widowed 4 Divorced "natural". Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede com 16b. Kind of Business/Industry rede completed) nd Mental Hygiene. marked other than College (1-4or 5+) Elementery/Secondery (0-12) Accountant Manufacturing Taylinit. Pages 1 end 2 should be file Department of Health end Mental Hy Important: If Item 27 is marked other any Injury or other treumstic event 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Surneme) Be 2 William Clarence Burton Margaret May Martin 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Kay F. Hayes 671 South Shore Drive, Southport, NC (sister) 28461 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Date 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Cedar Hill Cemetery 2/12/99 Suitland, MD Francis J. Collins Funeral 21. Signeture of Funeral Servica Licensee 22. Name and Address of Fecility Home, Inc. 500 University Blvd. West Silver Spring, MD 20901 trond Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical years Metastatic Lung Cancer Examiner Due to (or es e consequença of) Physician/Medical Examiner physician end the burief-trensit Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): certificate be Due to (or es e consequenca of) 98 ettending 990 0 Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. the 23b. Did tobacco use contribute to the cause of death? signed by the 1 No 3 Probably 4 Unknown by 24b. Were autopsy findings eveilable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy peed performed has pege 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 27. Menner of Deeth After t 28d. Describe how Injury occurred or Attanding 1 Maturel 5 Pending Investigation a Eunaral Diractor: Aft Director: Aft detely filled in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Sulcide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred et the time, date end pleca, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the bests of exemination end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner steted. Medicai (Check only one) within 2 29b. Signeture end title of cartifier 29d. Date signed (Month, Dey, Year) 29c. License number D08944 February 9, 1999 10 30. Name end eddress of person who completed the of deeth (Item 23e) (Type, Print) 3720 Farragut Avenue, Kensington, MD Martin C. Shargel, M.D. 20895 31. Dete filed (Month, Dey, Yeer) FEB 10

32. Registrer's Signeture

DHMH 16 Rev 6/95

State Registrar

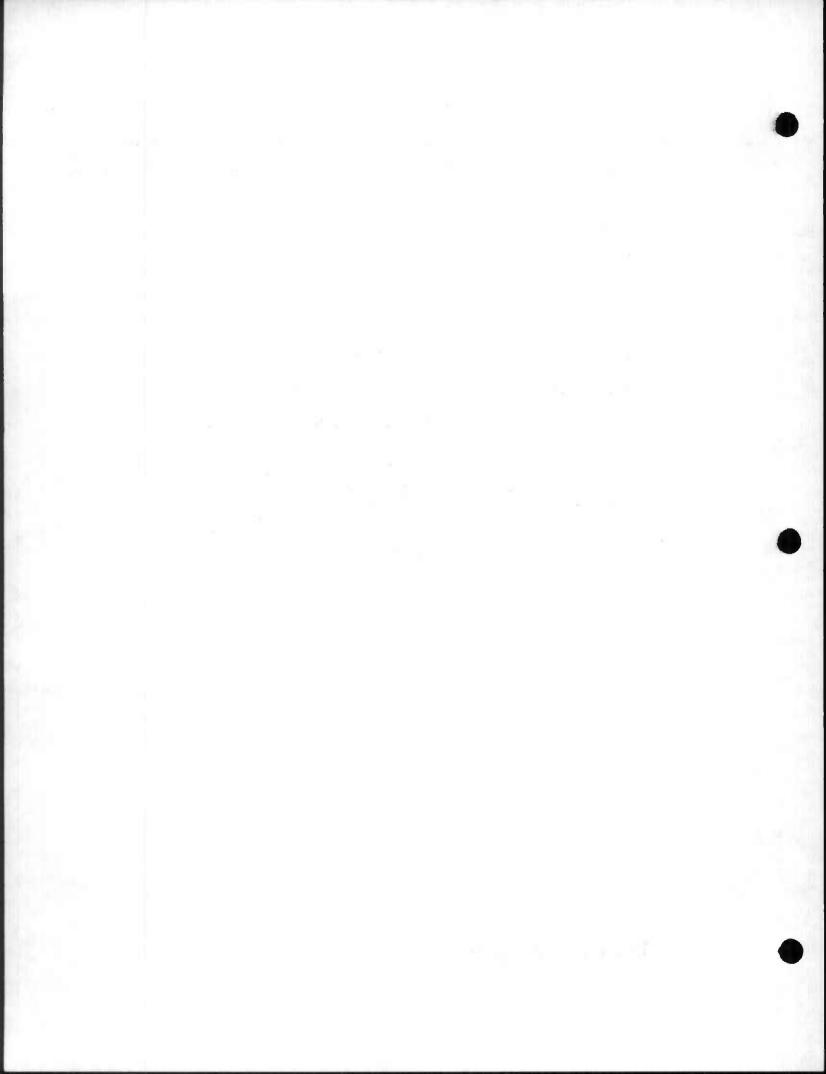
Baltimore, Maryland 21215-0020

Box 68760.

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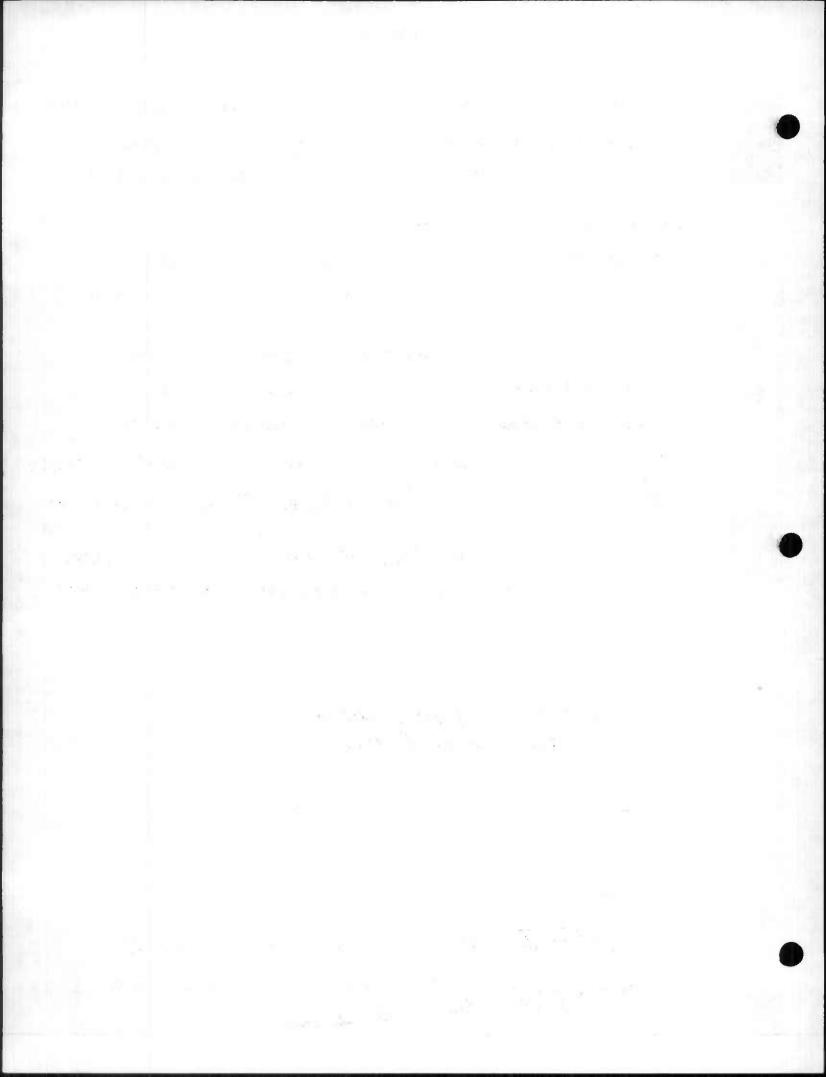
of Vital Records,

Division



State of Maryland / Department of Health and Mental Hygiene

				Certi	ficate of	Death	Re	g. No.	05311
Dhue	olon	1. Decedent's Neme (First, Middle, La					2. Dete of Deet Month	-	3. Time of Deeth
Physi /Med		ELIZABET	H FORNARA	CO	STELL	0	FEBRUAL	RY 4,1	999 8:25pm
Exam		4a. Fecility Neme (If not institution, giv	and the same of th			4b. City, Town, or L	ocation of Deeth	4c. County	of Deeth
			Health Care Ce			Easton		Tall	oot
Funera Directo		5. Social Security Number 6. S 110-10-1641 Usual Residence of Decedent	7. Age (In yrs. 96		Onths Deys		8. Date of Birth (Month, Dey, Sept. 2		Birthplece (State or Foreign Country) New York
land		10a. State 10b. County	10c. Cit	ty, Town or Locat	ion				10d. Inside City Limits
death with the Maryland ms 23a or 28a-f ehow r must be notitied at	to	Maryland Talbot		Bozman					1 ☐ Yes 2 ▼No
r 282	Director	10e. Street end Number			10f. Zip Code		10	Og. Citizen of V	Vhet Country?
h wit	Ω Θ	23432 Berry Rd.			216	119		U.S.A.	
dea	Funerai	11. Marital Status	12. Was Decedent Ever In U Armed Forces?	,S. 13. We		Hispenic Orlgin? (Spoen, Mexican, Puerto	ecify Yes or No-	14. Race	e - American Indien,
Datallinore, Midryland 212.13-0020 permit. Peges 1 end 2 should be filed within 72 hours efter death with the Marylan Depertment of Health end Mentel Hygiene. Important: If Itam 27 is marked other than "naturel; or items 23a or 28a-f show any Injury or other traumatic event, the Mexical Examines must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give X Yeer or Dates:		Yes 2X No		rican, etc.)		k, White, etc. White
5-0 72 ho	Completed	15. Decedent's Ed (Specify only highest gre	ducetion	16e. Deceden	t's Usuel Occu	petion	ina	16b. Kind of Bu	siness/industry
within within than " we	de la	Elementery/Secondery (0-12)	College (1-4or 5+)	life. DO	NOT use retire	during most of work ed)	ang .		
d 212 filed withi Hygiene. ort, the	S	6		Seamst	ress	Homemake		Hon	
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Mar 12 sho 16 m		19a. Informent's Neme/Reletionship (t end Number or Rui			
1 end 2 Health am 27 i		Gay Hearn	Niece		ers Av		enham, P		19012
Destriction of the beginning of the beginning of the myortant: if item 3 any Injury or other		20a. Method of Disposition 1 XBuriel 2 Cremetion 3 C	Removal from State	Plece of Dispositi cometery, cremet	ory or other ple	ece)	Dete	20c. Location -	City or Town, Stete
Affice to executed with the principle of	l -	23a. Paff11. Enter the disease, or com shock, or heart feilure. List only Immediete Ceuse (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying	a. garta Due to (c b. Suspec	or as a consequent	t, with a ce of dy control of the control of the ce of t	Heel Hicular	or respiretory arre	er hog-	Approximate Interval Between Onset and Deeth Ady 5 Ady 5
flicete be ex physician sthe burie	E E	ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events	c						
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the ed	Sic	Pert II. Other significant conditions of	ontributing to death but not res	uiting In the unde	rlying cause g	iven in Pert I.	23b. Dld to	bacco usa cor	ntributa to the causa of death
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The COIDS, T.O. BOX 00/00, The law requires that the death certificate be executed ste has been signed by the ettending physician and page 2 should be deteched for use as the bunfal-transit	Completed	0/	trick to b	-riga	MM		24e. Wes er perform	n eutopsy ned?	24b. Were autopsy findings eveileble prior to completion of ceuse of death?
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vician: The certificete rector, pag	Be (25. Wes case referred to medicel exeminer?				26. Plece of Deel	th (Check only on	э)	
Physic this ce	2	1 Ves 2 No	Hospitel: 1 ☐ Inpatient 2 ☐	ER/Outpetient	3□ DOA Ot	ther: 42 Nursing Ho	ome 5 Reside	nce 8 Othe	er (Specify)
Attanding Physician: r death. sector: After this certific by the funeral director,		27. Manner of Deeth 1 Neturel 5 Pending 2 Accident Investigation	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inju Wo M 1	ork? □ Yes 2 □ No	28d. Describe ho	w Injury occurr	ed
Olvision of vitality of a Attanding Physician: 1 effer death. Director: Affer this certificel in by the funeral director, p	Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury - At he building, etc. (Specif	ome, farm, street (y)	factory, office		28f. Location (St. City or Town	reet end Numb , Stete)	er or Rurel Route Number,
To the Hospital or Attanding Physician: within 24 hours efter death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical C	29e. Certifier 1 Cartifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examine end menner stated.	wiedge, deeth od tion end/or inves	curred et the ti igetion, in my	ime, date end plece, opinion, deeth occur	end due to the ce red et the time, de	use(s) end me ete end plece, e	nner es steted. end due to the ceuse(s)
To th Within To th	Me	29b. Signature end title of	AB WI			se number	29	2/5/	(Month, Dey, Year)
		30. Name end eddress of person who	completed cause of death (Item	n 23e) (Type, Pri		. , , ,		1 - 1	
				E00 T 11		Ave. East	on Mana	land 9	1601
S Regis	tate trar	Robert B. Sa	nchez M.D. 8 1999 Registrer Signe	eture		3300	on, wary	rand 2	TOOT
ricgis					1. do	als			



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item #10b, per F.D. 2/5/99, Carroll County, wil Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** VIRGIL HENRY CAIN, SR. Feb 4:28 AM /Medical 4a. Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Washington FAHRNEY-KEEDY NURSING HOME BOONESBORO 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Sacurity Number Birthplaca (Stata or Foreign Country) **Funeral** Days Hours 1 1 M 2 □ F 90 Yrs. 578-03-1024 Director FEB 1, 1909 MARYLAND Usual Rasidanca of Decedent 10b. County 10a. Stata 10c. City, Town or Location ns 23a or 28a-f show 10d. Inside City Limits MONTGOMERY 1 Yes 2ENO Director MARYLAND WASHINGTON SILVER SPRING 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 12702 HELEN ROAD 20906 UNITED STATES items 23a Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, White, etc. Nas 2 No If Yes, Give Yaar or Dalas; WWII 1 Navar Marriad 2 Married 8 1 ☐ Yas 3 ☐ No Specify: Specify: by 3€Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Spacify only highest greda complated) 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry Elementery/Secondery (0-12) College (1-4or 5+) COMMERICIAL PLASTERER CONSTRUCTION Maryland 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) d 2 should be fi th and Mental H 7 Is marked ott ANDREW LEE CAIN LILLIE ANN MULLINIX 19a. Informent's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) nt of Haalth a if item 27 is or other trai 605 E. ORANGE ST, VIRGIL H. CAIN, JR/SON SHIPPENSBURG, PA 17257 Baltimore, 20b. Pieca of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata XXBurial 2 Cramation 3 Removel from Stata Department of Important: If any Injury or once. 4 ☐ Donetion 5 ☐ Othar (Specify) TAYLORSVILLE U.M. CEMETERY 2/6 TAYLORSVILLE, MD Signetura of Funeral Sarvica Licanses 22. Nama and Address of Facility 91 WILLIS STREET MYERS FUNERAL HOME WESTMINSTER, MD 21157
Approximate Interval Between Conset and Death 23a. Part1. Enter tha disaasa, or complications and shock, or haart failura. List only ona causa on aach **Physician** Immediata Causa (Final disaesa or condition resulting in death) /Medical Protable Preumonia 3-4dgs Examiner Dua to (or as e consequence of): 6 m Carcinone Colo Sequantially list conditions, if any, laading to immadiate cause. Entar Undarlying Cause (Diseasa or Injury that initiated avants rasulting in death) Last Dua to (or es a consequence of) Physician/Medical Dua to (or as e consaguanca of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Whiknown þ 24b. Were eutopsy findings aveilabla prior to completion of cause of daath? Completed 24e. Was an autopsy performed? 1 Yas 2 HV6 1 TYas 2 No 25. Was case refarred to medical exeminar? Be 26. Piece of Daath (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Othar: 4 Aursing Homa 5 Rasidanca 6 Othar (Specify) ŏ 27. Mannar of Daath 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Panding Invastigation 1 ANaturel 1 Yas 2 No 2 Accidant 6 Could not ba datarminad 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Piaca of Injury - At home, farm, straat, factory, offica building, atc. (Spacify) 4 Homicide 29a. Cartifiar 1 Certifying Physicien: To the best of my knowladga, daath occurrad et tha tima, data and place, and due to the ceusa(s) end manner as statad. Medicai (Check only one) 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the causa(s) end manner stated. å 29b. Signatura and titla of certifiar 29c. Licanse number 29d. Data signed (Month, Dey, Year) - TOSE MO FEBRUARY 4, 1999 D18019 30. Nama and addrass of person who completed ceuse of death (Item 23a) (Typa, Print) VASANT DATTA, M.D. 334 Mill Street, Hagerstown, MD 21740

DHMH 16 Rev 6/95

State Registrar 31. Data filed (Month, Day, Year)

FEB 0 5 1999

32. Registrer's Signature

Henry

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State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** 5, 1999 Juliann Helen Copenhaver February 8:35pm /Medical 4a. Facility Nama (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplace (Steta or Foraign Country) 8. Date of Birth (Month, Dey, Year) **Funeral** 1 ☐ M 28%F Deys Director Yrs. 57 169-32-9035 Mar. 18, 1941 Pennsylvania Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exactiner mail to notified at 1 ☐ Yes 212 No Director Maryland Worcester Berlin 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12 Leslie Mews 21811 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Yaar or Datas: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Rican, atc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural", White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry should be filed within 7/ and Mentel Hygiene. (Specify only highest greda completed) Elementary/Secondery (0-12) College (1-4or 5+) 5+ Nurse Medical permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If Nam 27 is marked oths any injury or other traumatic avant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be 2 Joseph Melli Helen Palovcak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) William F. Copenhaver (Husband) 403 Kent Oaks Way, Gaithersburg, MD 20878 20b. Place of Disposition (Nema of cemetery, crametory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Sepulchre Cemetery 2/9/99 | Philadelphia, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate nterval Bety Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) a Cardio-Respiratory Arrest Examiner Due to (or es a consequence of): Examiner Massive Subarachnoid Bleed buriel-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last end Due to (or es a consequence of): physician e the buriel Two Cerebral Aneurysm Physician/Medical Due to (or as a consequence of). attending Poly Cytic Kidney ō signed by the at d be deteched for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t, 23b. Did tobacco usa contribute to the causa of death? 1 Yes 2 No 3 Probably 4 to Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen pege 2 1 ☐ Yes 2X No 1 ☐ Yas 2 ☐ No certificate To the Hospital or Attending Physician: Within 24 hours effer death. To the Funeral Director: After this certifica 25. Wes cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No funeral 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury et Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Š 4 Homlcide 1 🔀 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner es steted. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and magner stated. 29b. Signature and 29c. License number 29d. Date signed (Month, Dey, Year) To D 29224 February 6, 1999 and address of person who completed cause of death (Item 23e) (Type, Print) Saied Jamshidi 6801 Georgia Avenue, Silver Spring, MD 31. Data filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

FEB 09

1999

the Marylend

death

72 hours efter

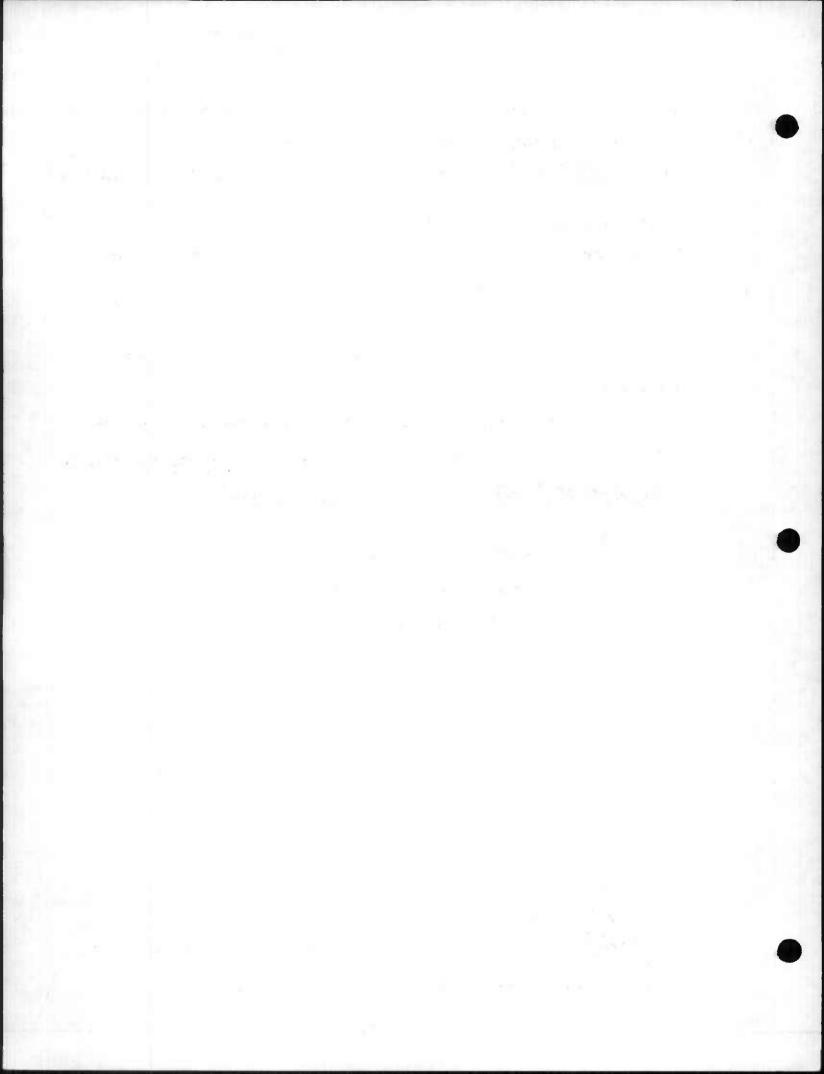
Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Division of Vital Records.

that the death certificate be



State of Maryland / Department of Health and Mental Hygiene 🔾 🔾 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** CROFT FLUTENCE February 9:35 A.M. /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13018 Morning Side Lane Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
September 19, 1916 Vermont 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1□M 2 F Yrs. 009-07-6123 Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 te marked other than "natural", or items 23s or 28s-f show other treumetic event, the Medical Examiner must be notified at 1 Yes 2 No Director Montgomery Silver Spring 10a. Street and Number 10f. Zip Code 10g, Citizen of What Country? 13018 Morning Side Lane 20904 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hyglene. Important: If item 27 ie marked other than "natural", or heme 22-any Injury or other treumstin average. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: à 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Social Worker Healthcare 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George C. Stufflebeam Eva Mae Chaffee 2 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June Metcalf/daughter 13018 Morning Side Ln. Silver Spring, MD 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a Method of Disposition 20c. Location - City or Town, Stete Date 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Chesapeake Crematory 2/8/99 4 ☐ Donetion 5 ☐ Other (Specify) Beltsville, MD 22. Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signeture of Funeral Service Licansee (lla Somelo 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Pert1. Enter the disease, on complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List enty one cause on each line. Approximate Interval Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical RESpiratory Failurd Examiner Due to (or es e consequence of): Examiner Months Cancer physician and s the burial-transit The law requires that the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initialed events resulting in death) Last Due to (or es a consequence of): Obstructive P.O. Box 68760 Physician/Medical Due to (or es e cons Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2□ No 3 Probably 4 Unknown Records, Be Completed by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy performed? Is cartificata I director, page 2 2 No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this cartifica staly filled in by the funeral director, p 25. Wes case referred to medical 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Naturel 5 Pending Investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 T Homicide To the Hospital or within 24 hours aft To the Funerel Di compietaly filled in 29a. Certifier 1 Ccritifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner steted. 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number YOSTAL ABALL MD 80053317 February 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 11501 GEORGIA AVENUE SLITE SIT Whoaton MD JOSEPH ABALL

DHMH 16 Rev 6/95

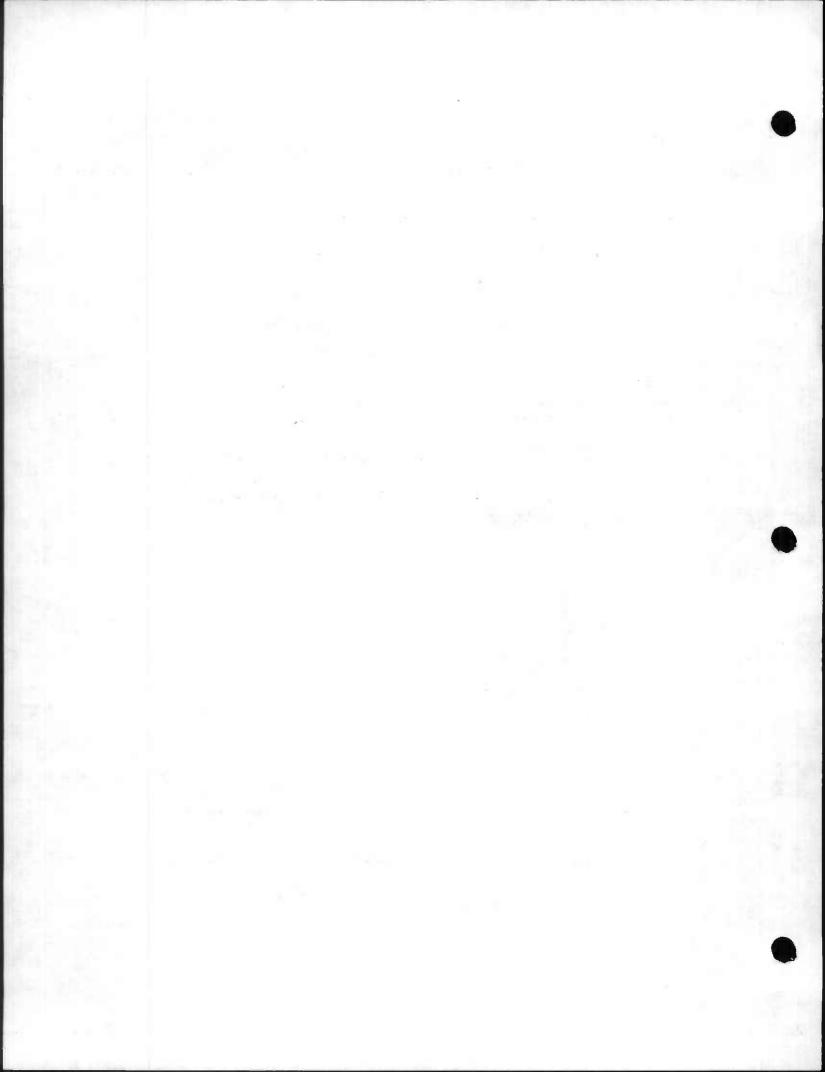
State

Registrar

31. Dete tiled (Month, Dey, Year)

FEB 0 8 1999

32. Registrer's Signeture



				Ce	rtifica	ate of	Death			Reg.	No.	Ub	381
Physician /Medical	Decedent's Neme (First, Middle, I John Raymond		Sr.						2. Date of Month Feb .		Day 1999	Yeer	3. Time of Death 10:00AM
Examiner	4a Facility Nama (If not institution, g					4	b. City, To	own, or Lo	cation of D		4c. County	of Death	
	6620 Bradley B	lvd.						esda				tgomer	ry
Funeral Director	5. Social Security Number 6 216-40-5862		7. Age (In yrs. 96	last birthday Yrs.	Month	ler 1 Year s Days	If Under Hours	24 Hrs. Min.	8. Date of (Month, July	Birth Dey, Ye	1902	9. Birthpiae Country Conne	ce (Stete or Foreign y) ecticut
D	Usuel Residence of Decedent												
Menyler and show filed at	MD 10b. County Montgo	mery		ty, Town or L chesda	ocation							100	d. Inside City Limits 1 1 Yes 2 No
3a or 28a It by not	10e. Street end Number 6620 Bradley Blv	d.				Zip Code					Citizen of	What Country	γ?
Aaryland 21215-0020 2 should be lifed within 72 hours after death with the Meryland and Mental hygiene. Is marked other than "naturel", or items 23s or 28s-f show reumstic event, the Medical Exercite from the notified. To Be Completed by Funeral Director	3 ₩ Widowed 4 Divorcad	12. Was Deced	ces? 2 EX No	J,S. 13.	Was Dec				ecify Yes or Rican, atc.)	No-		e - American ck, White, at y: Whi	c.
Maryland 21215-0020 d 2 should be liled within 72 hours af th and Mental Hygiene. 7 is marked other than "naturel", or treumatic event, the Medical Exam To Be Completed by I	15. Dacedent's (Specify only highest of	rede completed)	5,4-1	16a. Dece (Give life.	edent's Use kind of the DO NOT	suai Occup work dona use retired	ation during mos	st of worki	ing	161	o. Kind of B	usiness/Indu	stry
with with the than than	Elementary/Secondery (0-12)	College (1-	4or 5+)	Veter						S	elf e	mploye	d
Hygin Co.	17. Fether's Neme (First, Middle, La			, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			18. Moth	er's Neme	(First, Mid		den Suman		
d be defined on the contract of the contract o	Ellis Currey						Ade1	ine l	Reffe	Lt			
re, Maryls s 1 and 2 should t Heelth and Mer teem 27 is marke other treumatic	19a. Informant's Name/Relationship	(Type, Print)									ity or Town,	Stete, Zip C	iode)
allimore, runi. Pages 1 and partment of Heelth portant: If item 27 y injury or other tes.	Gordon R. Currey 20a. Mathod of Disposition 1 Burial 2 ACremation 3	Son		Ptace of Disp cometery, cre	osition (A	ieme of r other pled	(a)		Date	200	c. Location	City or Tow	
Pag Pag ment mrt: H	4 Donation 5 Other (Specialistics)		Da	ltimor emator	e/Wa	shing	ton		/5/99	Lè	mrer,	Mary!	Land
patitimore, Ma permit. Pages 1 and 2. Department of Heelth at Important: if item 27 is any injury or other tree	21 Signature of Funeral Service Lic	9/1509		J	2. Name osep	and Addre	ler's	Son		513	0 Wis	consir	n Ave. NW
Physician	23a. Part 1. Enter the disease, or co shock, or head takere. List on	mplications that ca ly one cause on se	used the dea ch tine.							y arrast		- 11	Approximete nterval Between Onset and Deeth
/Medical Examiner	Immediate Cause (Final disaesa or condition resulting in death)		ted Cardiomyopathy							4			
<u> </u>				or es e conse		f):						1	
nsit min		b		scler								<u> </u>	
68 / 60, ifficate be executed g physician end as the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.												
	resulting In deeth) Lest		Due to (d	or as a conse	quenca o	f):							
P.O. BOX nat the death certified by the attending letached for use a Physician/M	Part it. Other significant conditions	d	ith but not re	sulting in the	underlyini	r cause oiv	en in Part	1	23b. [oid toba	cco use co	ntribute to t	he cause of death
P.C. hat the detached by the d									1	☐ Yes	2 No	3 Proba	bly 4 Unknow
requii						4				Ves en e erforme		com	e eutopsy findings labla prior to pletion of cause sath?
The law rate has page 2									1	☐ Yes	2 X No	10	Yas 2□ No
VITAL I	25. Was case referred to medical						26. Pleci	e of Deeti	n (Check or				
	examiner? 1 Yes 2 No	Hospital: 1 1 In	patiant 2	ER/Outpetie	ent 3	DOA Oth	OF:	ursing Ho			a 6 □Ott	ner (Specify)	
on or ding Phys h. After this funeral d	27. Menner of Death 1 X Natural 5 ☐ Pending	28e. Date of (Month		28b. Time Injury		28c. Injur Wor					injury occur		
IVISI r Atten ter deat rector: n by the	2 Accident Investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place o	of Injury - At h g, etc. <i>(Speci</i>	ome, farm, s						n (Stree Town, S		ber or Rural I	Route Number,
O the Hospital or ithin 24 hours at or the Funeral DI ompletely fitted in Medical Cel		Physician: To the baseminar: On the base and manner	is of examina										
ithin of the sample of the sam	29b. Signatura and titia of certifiar				1	9c. Licans	a number			29d.	. Data signe	ed (Month, Di	ay, Year)

State Registrar

31. Data fited (Month, Day, Yaar) FEB 0 8 1999

Allen A. Nimetz MD.,

30. Name end eddress of person who complete cause of death (Item 23e) (Type, Print)

5401 Western Ave. NW, Washington, DC 20016-2998

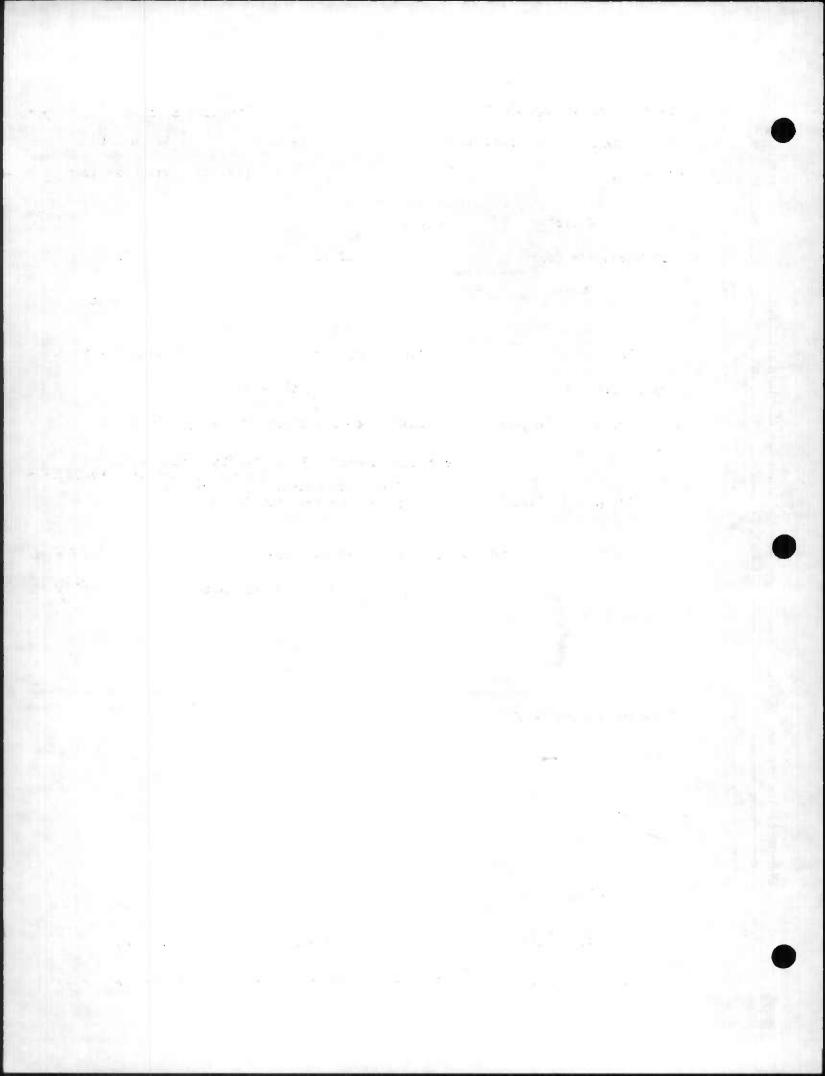
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O. O.

1. Decedant's Name (First, Middle	ı, Last)	11171		ficate of		2. Data of De			3. Tima of Death				
						Month	Day	Yaar					
Omar James 4a Facility Name (If not institution	Dashiell	-)			4b. City. Town, or	Februar Location of Death		of Death	5:30 p.m.				
Frederick Memo					Frederi			erick					
5. Social Security Number			ast birthday)	f Under 1 Year	If Undar 24 Hrs				ce (Stata or Foreign				
578-22-6400 Usual Rasidance of Decedent	1⊠M 2□F	86	Yrs.	lonths Days	Hours Min	8. Data of Bin Month, Da Dec. 25	, 1912	Mary I	ce (Stata or Foreign v) .and				
10a. State 10b. County		10c. City	, Town or Locat	ion				100	f. Insida City Limita				
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10e. Street and Number				10f. Zip Coda			10g. Citizen of V	What Country	y?				
6250 Woodwinds	Court			2177	1		1	USA					
11. Marital Status	12. Was Daceden Armed Forcas	f Evar in U.	S. 13. Wa	s Dacedant of H	lispanic Origin? (Specify Yaa or No		e - Americar ck, Whita, at					
1 ☐ Nevar Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced		No		Yas 2₺ No			Specify						
15. Decedant	's Education		16a. Dacedan	t's Usual Occup	pation during most of wo	nut in a	16b. Kind of Bu	usiness/Indu	stry				
(Spacify only highas Elementery/Secondary (0-12)	Collaga (1-40)	5+)	lifa. DO	NOT usa ratire	d) most or wo	orking							
12			Postal	Employ	ee		Federa.	1 Gove	rnment				
17. Father's Name (First, Middle, I	Last)				18. Mothar's Na	ıma (First, Middle,	Maidan Sumam	na)					
Omar Dashiell					Haile H								
19a. Informant's Name/Ralations						Rural Routa Numbe			Coda)				
	(daughter)	201 20	6250 We lace of Dispositi		s Court,	Mt. Air	y, MD .	21771	- 01-1-				
20a. Mathod of Disposition 1 ဩ Buriel 2 ☐ Cramation	3 Ramoval from State	Cé	ematary, cramat	ory or other pla		Data	200. Location -	City of Tow	11, 31818				
4 Donetion 5 Othar (Sp		Par	rklawn N			2/8/99	Rockvil						
21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Francis J. Collins Funeral House Inc. 500 University Blvd. West													
Silver Spring, MD 20901 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate													
23a. Part1. Entar tha disaasa, or shock, or haart failura. List	complications that cause only ona causa on aach	ad the daath lina.	n. Do not enter t	he moda of dyli	ng, such as cardia	ac or raspiratory a	rrast,		Approximata ntarval Batween Onsat and Death				
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CONGESTIVE HEART FAILURE													
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resulting in death) Last Dua to (or as a consequence of):													
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Part II. Other algnificant conditio	ns contributing to death	but not rasu	ulting In the unde	rlying cause gi	ven In Pert I.	23b. Did	tobacco uae co	ntribute to 1	the cause of death				
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CAPERTITO	111111					-			0.0				
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examiner? 1 Yas 2 No 27. Mannar of Death 1 Natural 5 Pandin Invastig 2 Accidant 3 Suicida 6 Could r datarm 29a. Cartifier Check only one) 29b. Signature end fitte of Striffar 30. Nama and addrass of parson of the control of t	28a. Data of In (Month, Data) 28a. Place of It building, a gray physician: To the best and mannar s	iury ay Year) njury - At ho atc. (Specify t of my know of axaminat statad.	28b. Tima of Injury oma, farm, straat () wledge, death or invas	28c. Inju Wo M 1 Courred et the titigation, in my courred et the titigation.	her: 4 Nursing ry at rk? I Yas 2 No me, data end plat opinion, daath occ sa number	28d. Describe 28f. Location (City or Tol	Street and Number, State) causa(s) end made and place, 29d. Data signa	oper or Rural anner as ste and dua to to d (Month, D	Routa Number, ted. tha cause(s) ay, Year)				



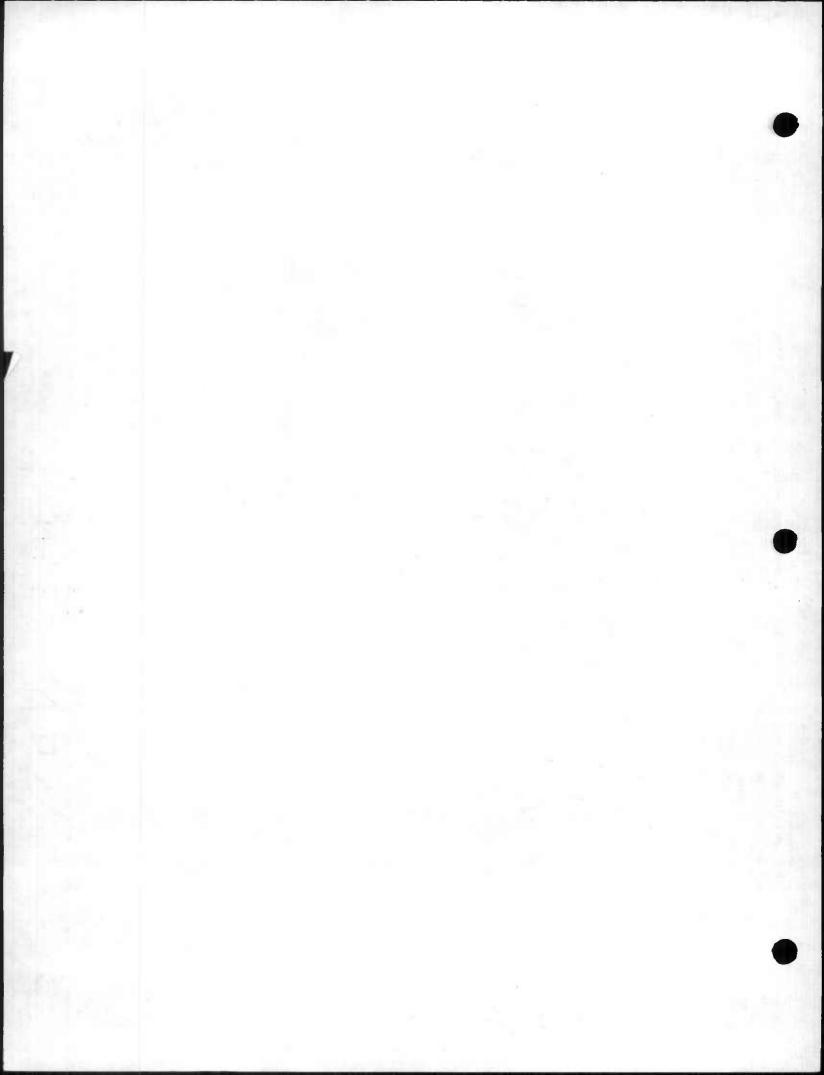
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Dom Ksey 09:07fm elen C Feb /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Localion of Death 4c. County of Death Examiner Holy Cross pospetal Sulver String montgomeny If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 9. Birthplace (State or Foreign Country) 1912 New York 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Months 1 M 2 X F 86 083-10-0210 Oct. Director Usual Residence of Decedent Departit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If hem 27 Is marked other than "natural", or Itema 23a or 28e-f show eny injury or other traumatic event, the Medial Eventual pressible and injury or other traumatic event, the Medial Eventual pressible and injury or other traumatic event, the Medial Eventual pressible and 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Prince Georges Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of Whel Country? 20770 7016 Megan Lane USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Marital Status 1 Never Merried 2 Married Raltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Cotlege (1-4or 5+) Sales Retail 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Ellen G. O'Brien Patrick H. Mackay 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 7016 Megan Lane, Greenbelt, MD 20770 (daughter) Helen M. Thomas 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removet from State 2/13/99 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia 22. Name and Address of Facility Francis J. Collins Funeral 21. Signature of Funeral Service Licensee Home, Inc. 500 University Blvd. West Silver Spring, MD Silver Spring, MD 20901

23a. Part. Inter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Cardiac Arrythmia 15 Minutes Examiner Due to (or as a consequence of): Examine 5 minutes Cardiac Arrest The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760, Physician/Medical Due to (or es a consequence of): esn. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dfd tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Myocardiopathy Completed by 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 Proutpatient 3 DOA After this 28a. Dete of Injury (Month, Day Year) 27. Manner of Daath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deal To the Funerel Director: 6 Couid not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 29a. Certifier 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. Medical completely 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)
RAMAN R. TULI, MD 10810 BARNES TOWN ROAD SUITE 202 CAITHERS BYRG.
MD 20878

State Registrar 31. Date fited (Month, Dey, Year)

DHMH 16 Rev 6/95

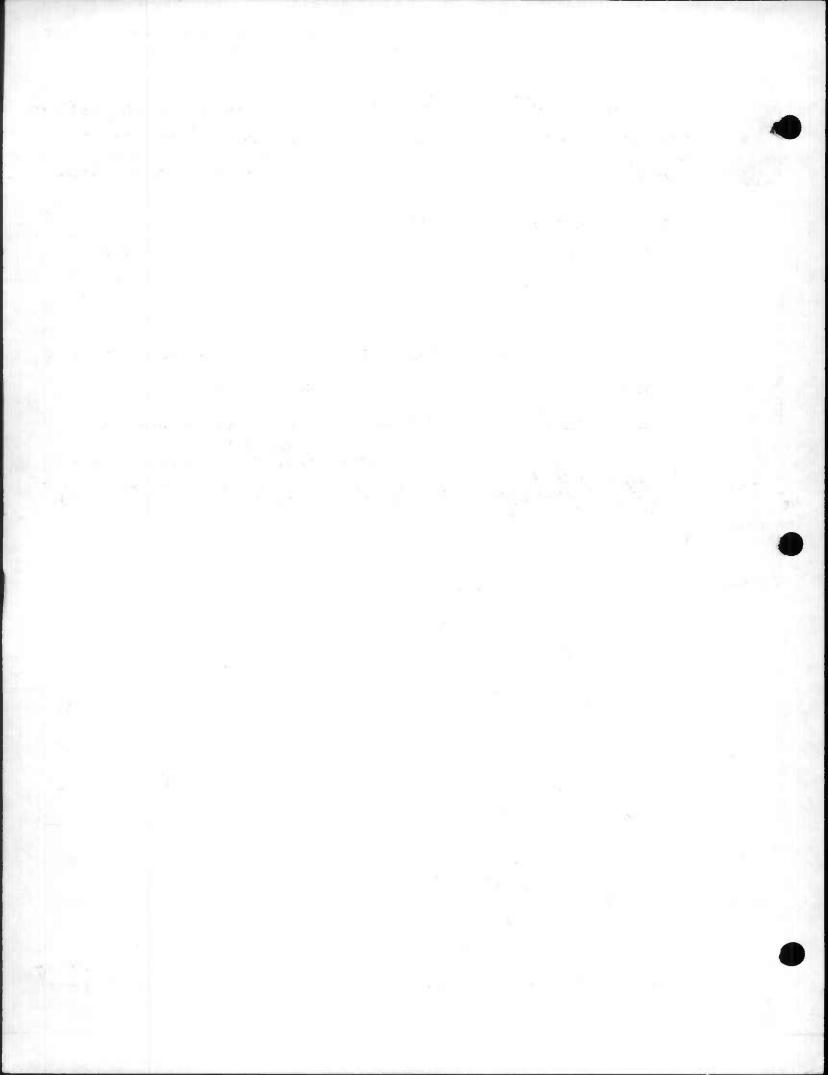
32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3 Time of Deeth Month **Physician** Davis John 1635 PM tebruary 1999 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Rockville, MD Montgomery Shady Grove Adventist Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 8. Date of Birth (Month, Dey, Year) 9. Birthplece (State or Foreign Country) February 10, 1927 West Virginia **Funeral** Months Deys Hours 1 X M 2 □ F 71 Yrs. Director 216-22-7268 Usuel Residence of Deceden the Meryland 10e Stete 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 6400 Wilmett Road 20817 United States Items 23a Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11 Marital Status 72 hours efter 1 X Yes 2 No If Yes, Give Yeer or Dates: WW II 1 ☐ Never Married 2 Merried Baltimore, Maryland 21215-0020 6 1 ☐ Yes 2X No Specify: White PV 3 ☐ Widowed 4 ☐ Divorced natural', Completed 15. Decedent's Education (Specify only highest grade completed) 18e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 Senior Editor United States Government other 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health end Mentel Hant: If Item 27 Is marked oth Be Robert A. Davis Margaret M. Gilmore 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health er Important: If Item 27 is sny Injury or other trau once. Ada R. Davis/Wife 6400 Wilmett Road, Bethesda, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) February 10, 1999 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 X Cremation 3 ☐ Removel from State 4 Donetion 5 Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M00846 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only the caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Onset end Deeth **Physician** /Medicai Immediate Cause (Final disease or condition resulting in death) JEPS15 Examine Due to (or as e consequence of): Examiner PHOCHEDITIS The law requires that the death certificete be executed physician and s the bunal-transit Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Box 68760. YELL EIBEILHOUN Physician/Medical Due to (or as e consequence of): attanding p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 100 3 1 Yes 2 No 3 Probably 4 Unknown signed d be dat Records, by 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? been si Completed 24s. Was an autopsy performed? page 2 s 1 Yes 2 1 No 1 ☐ Yes 2 ☐ No certificate Division of Vital al or Attending Physicien: Ts aftar deeth.

N Director: After this certificated in by the funeral director, pa 25. Was case referred to medical examiner? Be 25. Place of Death (Check only one) 1 Yes 20€No Hospital: 1 Dengation 2 □ EP/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month. Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No 2 Accident 6 € Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 D Homicide To the Hospital or within 24 hours aft To the Funeral Dil complataly filled in 29a. Certifier Medical To the best of my kno egge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examinand manner stated. nd/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) H 51280 11 5 30. Name end eddress of person who completed cause of death (Item 234) (Type, Print) BASCAR, DP. 13219 Executive Paule Terrace, Germonton ANUSH 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State FEB 11 1999 Registrar

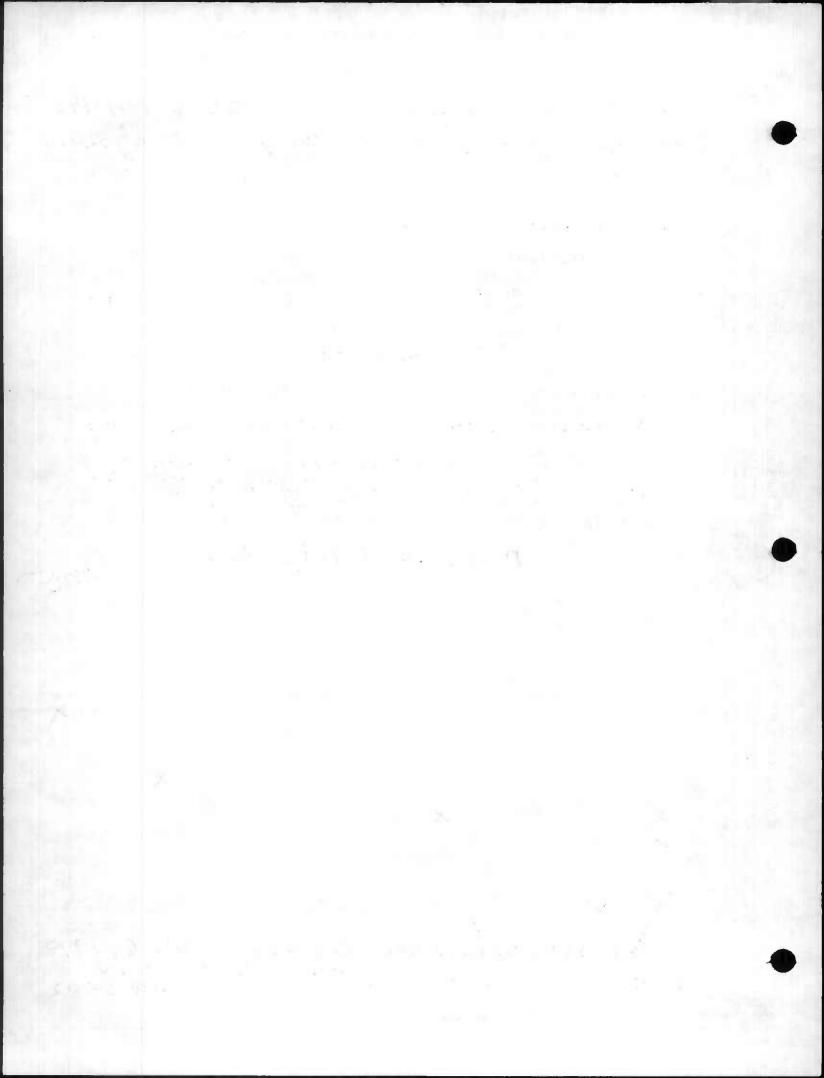


State of Maryland / Department of Health and Mental Hygiene (19)

Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Neme, (First, Middle, Last) Seb **Physician**)erengows 1935 0 Jal /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner mont Olnex mont 70 mer General DMERY if Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Birthplece (State of Foreign 6. Sex 7. Age (In yrs. lest birthday) **Funeral** Days 1₩ M 2□ F York 085-34-4873 56 July 18, 1942 New **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Meryland Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at 2006. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director MD Montgomery Derwood 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5312 Water Wheel Court 20855 USA Funeral 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Merital Stetus 1 ⊠ Yes 2 □ No
If Yes, Give
Year or Detes: 1964-67 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White λq 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Owner Sales Business 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Walter J. Derengowski Helen Kownacki 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. informent's Name/Reletionship (Type, Print) Jane M. Derengowski (wife) 5312 Water Wheel Court, Derwood, MD 20855 20b. Piace of Disposition (Name of cemetery, crematory or other piece) Date 20c. Location - City or Town, State 20e Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 2/11/99 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 22. Name and Address of Fecility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West 21. Signature of Funeral Service Licensee Silver Spring, MD 20901 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximete intervel Between Onset end Deeth Physician Immediate Ceuse (Finel disease or condition resulting in death) /Medical Examiner Due to (or es e consequence of) Physician/Medical Examiner ettending physician and for use es the buriel-transit The lew requires that the deeth certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): resulting in death) Last signed by the e Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed is certificate hes b director, page 2 s 25. Was case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 1 Inpatient this funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Yeer) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury et Work? Certification: After Hospital or Attending 5 Pending Investigation To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: Af 1 Tyes 2 No death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end placa, end due to the ceuse(s) and menner steted. edical 29d. Date signed (Month, Dey, Year) 29b. Sibo ure end title of certifier 1 M DME 10 + 2101 medical Port 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

LRR NERECNER, MODME ver Spring 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State FEB 10 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 2. Dete of Death 1 Decedent's Neme (First Middle Last) 3. Time of Deeth Month **Physician** February 5, 1999 Dilorio Mildred 6:45 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not Institution, giva street and number) Examiner Montgomery General Hospital 01ney Montgomery If Under 1 Year If Under 24 Hrs. 8. Deta of Birth (Month, Dey, Year) 5. Social Security Number 9. Birthplece (Stete or Foreigr Country) Brooklyn New York 7. Aga (In yrs. last birthday) 1□ M 2XXF 081-12-5363 Yrs. 88 July 28,1910 Usuei Residence of Decedent 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Montgomery County Silver Spring 1 Yes 2 No Director 10e. Street and Number 10g. Citizan of What Country? United States of America 10f. Zip Code 3700 International Drive 20908 Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Datas: 14. Race - American Indian, Black, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 No Specify: White Specify: þ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Spacify only highast grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Thrift Shop Salesperson 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surnema) Robert Logan Margaret Schwarz 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19017 Raines Drive, Derwood, Maryland 20855 Robert Dillorio/ Son 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Steta 20a. Method of Disposition Date February Burial 2 Cremation 3 Removal from State Woodbury. 10,1999 4 ☐ Donetion 5 ☐ Other (Specify) New North Cemetery Connecticut 22. Name and Addrass of Facility Munson-Lovetere Funeral Home, Inc. 06488 235 Main Street, North, Southbury, Connecticut Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset end Deeth Immediete Ceuse (Finel disease or condition resulting in death) Congston heart Forluce Due to (or es e consequence of) Physician/Medical Examiner Pheamonia Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events Due to (or as e consequence of): Dua fo (or as a consequance of) resulting in death) Last Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 | Yes 2 No 3 | Probebly 4 | Unknown osteo GrtKritis by 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed 1 ☐ Yes 2 ☑ No 1 Yes 2 No 25. Wes cese referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Yeer) 27. Menner of Deeth 28d. Describe how injury occurred 28h Time of 28c. Injury et Work? Certification: 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homiclde edicai 29a. Certifier 1 Cartifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Msdlcaf Exeminer: On the basis of axaminetion end/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) end menner stated. (Check only 29b. Signature and title of certifier 29c. Licansa number B. Sparls 30. Name and eddress of person who completed ceuse of deeth (Item 23e) (Typa, Print) HRTTHUR SCHOENGOLD MO 31. Dete filed (Month Rey, Year) FEB 10 1999 32. Registrer's Signeture

State Registra

Funeral

Director

r than "natural", or items 23s or 25s-f show the Medical Examiner must be notified at

the Marylar

72 hours after

Hygie

12 should be financial by the marked of

perplii. Pages 1 and 2 ah Départment of Health and Important. It item 27 is ma any injury or other traums once.

Physician

/Medical

Examiner

the attending physician and hed for use as the burial-transit

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within 24 hours after death.

To the Funeral Director: After this cartificate hes completely filled in by the funeral director, page 2

3

98

The lew requires that the death certificate be executed

Box 68760.

P.O.

Records.

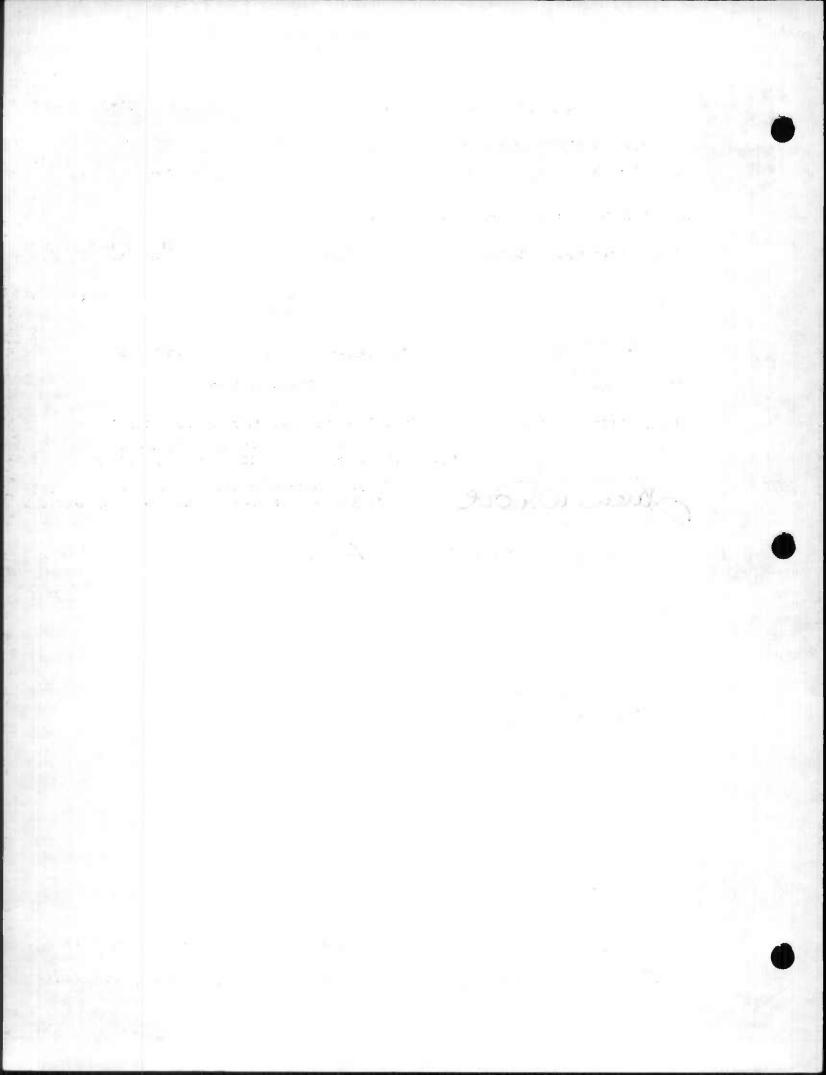
Division of Vital

Physician:

or Attending

To the

Baltimore,



Months

State of Maryland / Department of Health and Mental Hygiene () Certificate of Death Reg. No.

If Under 1 Yaar | If Under 24 Hrs.

Hours

Days

Physician	ı
/Medical	ŀ
Examiner	ı

1. Decedent's Name (First, Middle, Last) LILLIAN JUNE 4a Facility Name (If not institution, giva street and number)

2. Date of Death FEBRUARY 1, 1999 3. Time of Death 9:24 AM

filed within 72 hours efter deeth with the Meryland Hygiene. other than "natural", or items 23s or 28s-f ahow ent, the Medical Examiner must be notified at

7 is marked other traumatic event, i

Pages 1 and 2 should be file ment of Health and Mentel Hant: If item 27 is marked oth jury or other traumatic event

permit. Page Depertment of Important: If any injury or once.

Physician /Medical

Examiner

physician end s the buriel-trensit

88 for use es

ed by the a

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certificete

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After

Director: /

Hospital or Attending Physician:

deeth.

efter

To the Hospital or A within 24 hours efter To the Funeral Directompletely filled in by

The law requires that the deeth certificate be executed

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0020

GREATER BALTIMORE MEDICAL CENTER 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 🗓 F 213-50-2458 102

4b. City, Town, or Location of Death TOWSON

4c. County of Death BALTIMORE

Funeral Director

Usual Residence of Decedent 10a State MD Director 10e. Street and Number Funeral

P

Completed

Be

Examine

Physician/Medical

by

Completed

Be

Lo

Certification:

edical

10b. County GARRETT

10c. City, Town or Location MT. LAKE PARK

Yrs.

8. Date of Birth (Month, Day, JUNE 30 1896

9. Birthptace (State or Foraign PENNSYLVANIA

10f. Zip Coda 10g. Citizen of What Country? 21550

10d. Inside City Limits 1 N Yes 2 No

107 "E" STREET 11 Marital Status

1 Never Married 2 Married 3X Widowed 4 ☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 No If Yes, Give Yaar or Dates:

 Was Decedent of Hispanic Origin? (Specify Yas or Notif Yes, specify Cuban, Maxican, Puerto Rican, atc.) 1 ☐ Yes 2 No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Cotiege (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SCHOOL TEACHER

16b. Kind of Bustness/Industry

USA

Etementary/Secondary (0-12) 17. Father's Neme (First, Middle, Last)

JOHN

ANDERSON

18. Mother's Name (First, Middle, Maiden Surnama) CLARA

SWANSON

EDUCATION

19a. Informant's Neme/Reletionship (Type, Print)

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 820 LOYOLA DR.

MARGUARITE SCOTT - DAUGHTER

1 Buriai 2 □ Cramation 3 □ Ramoval from Stata

Q.

20b. Place of Disposition (Name of cemetery, crematory or other place)

TOWSON, MARYLAND 21204 Date

20c. Location - City or Town, State GARRETT MEMORIAL GARDENS 2/6/99 OAKLAND, MARYLAND

4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licenses

M00167

22. Name and Address of Facility

P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD 21550

de un

23a. Part1. Entar tha disaasa, or complications that ceused the daath. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximata Intervat Between Onset and Death

Immediate Cause (Final disaasa or condition resulting in death)

20a. Method of Disposition

Senility

Due to (or as a consequence of)

Due to (or as a consequence of):

Arteriosclerotic Cardio vascular disease

25 years

10 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that included support of the conditions of the c that initieted events resulting in death) Lest

Due to (or as a consequence of):

23b. Did tobacco use contribute to the cause of death? 20 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of ceuse of death?

1 ☐ Yes 2 No

1 Yes 2 No

25. Was cese referred to medical examiner? 1 ☐ Yes 2 No

27. Manner of Death

1 Naturei

2 Accident

3 ☐ Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

Hospitat: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☒ DOA 28e. Date of injury (Month, Day Year)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f.

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

3 S. THIRD STREET

Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 28c. injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

26. Piece of Deeth (Check only one)

OAKLAND, MD 21550

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29e. Certifie (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) and menner as atated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end piece, end due to the cause(s) and manner stated.

29b. Signatura and titla of certifian andi

D07258

29c. Licensa number

29d. Data signed (Month, Day, Year) February 3, 1999

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

A.E. MANCE, M.D.

State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year) - 4 1999 FEB

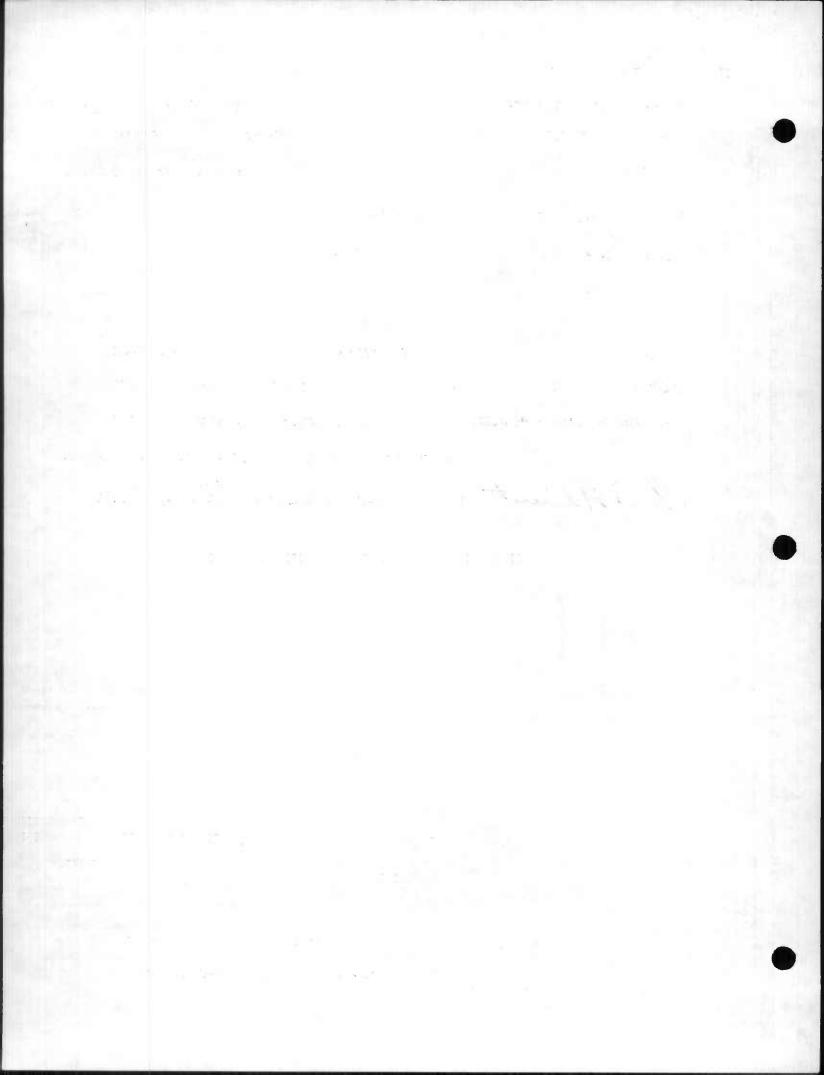
32. Registrar's Signature



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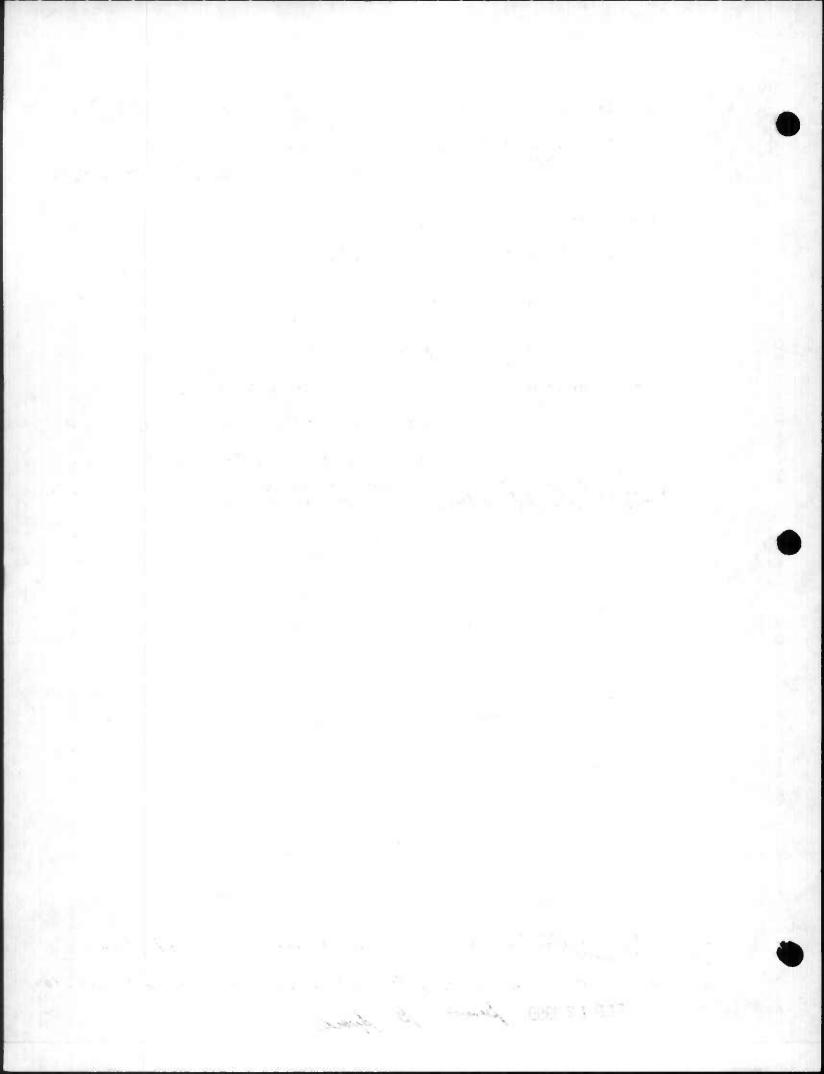
DEIDRE ANN	DEBERRY #23 PART I, 27, 28A-F	State of	of Marylar	nd / Depa	artmen	t of H	lealth and Death	Mental Hy	rgiene 9	0.5	388	
	1. Decedent's Neme (First, Middle, La		0709 3-1	0-33 001	mout	0011	Journ.	2. Dete of D		Yeer	3. Time of Death	
Physician · /Medical	DEIDRE ANN De	BERRY			E 7			FEB.	4, 1999	1 991	0433 AM	
Examiner	4e Fecility Neme (If not institution, gh GARRETT MEMORIA					4	lb. City, Town, o	or Location of Dee AND	th 4c. County			
Funeral Director		Sex 1□M 2∏ F	7. Age (In yrs. 21	lest birthday) Yrs.	If Under Months	1 Year Deys	If Under 24 H Hours Mi	n. (Month, D	irth ey. Yeer) 3, 1977	Cour	lece (Stete or Foreign try) Y LAND	7
pu au	Usuel Residence of Decedent 10a. Stete 10b. County		10c. Cit	ty, Town or Lo	cation					1	0d. Inside City Limits	
Maryi Heat	MD GARRET	Т		OAKLA	AND						1 X Yes 2 □ No	,
vith the Mai or 28a-f s be nottried Director	10e. Street end Number		1 1880	Line.	10f. Zip	Code			10g. Citizen of	Whet Cour	itry?	
ath w	114 E. ALDER STRI	_				550		10	USA	an Amaria	an Indian	
1215-0020 within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-1 show he Medical Evanime must be notified at properties by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed F	2XI No Sive		was Deced If Yes, spec I Pes	cify Cube	Specify:	(Specify Yes or Nerto Rican, etc.)		ce - Americ ock, White, by: WH	etc.	
5-0 72 ho	15. Decedent's E		0	16a. Deced	dent's Usua	el Occup	ation during most of w	vorkina	16b. Kind of B	Business/Inc	dustry	
Maryland 21215-0020 nd 2 should be filed within 72 hours aff tith end Mental hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam To Be Completed by F	Elementery/Secondary (0-12)		(1-4or 5+)	life. I	DO NOT U	se retired	9)		OWN H	HOME		
aryland 21215-0 should be filed within 72 ho do Mental Hygiene. marked other than "nature imatic event, the Medical. To Be Completed	12 17. Fether's Neme (First, Middle, Last	")	RAK.	1101	TETTAK	EK	18. Mother's N	leme (First, Middl				_
arylan should be nd Mental marked o umatic ev	DARWIN E	•	FRIEN	D			MARY	LYN	N -	HOWE	LL	
Aar 2 sho	19a. Informent's Name/Reletionship		AND					Rurel Route Num			Code)	
1 and 1 health Health orm 27 other tr	WM. WADE DeBERRY 20e. Method of Disposition	- HUSE		114 I			STREET	Dete	ND, MD 2		wn. Stete	
Pages nent of net: If the	1 ☑ Buriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Speci		n Stete	RTH GL	netory or o	ther plac		2/7/99	SWANTO			
Baltimore, Maryls pemil. Pages 1 and 2 should Department of Health and Mer Important: if Item 27 is marke any injury or other traumatic bncs.	21. Signature of Runeral Service Lice		_	22	2. Name er	d Addre	ss of Fecility	1	. BOX 24	43		
E/GUIN	23a. Pert1. Enter the diseese, or con shock, or heert feilure. List only	plications thet	MOO1							213.	Approximate Intervel Between	i
cartificate be executed radius by sicien and use as the burial-transit radius r	Immediate Ceuse (Final disease or condition resulting In deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest	e. SEIZU	Due to (d	ER COMPL or es e consec or es e consec	quence of):	BY I	POSITIONA	L ASPHYXIA				
		d										
. 0 0 %	Part II. Other significant conditions	23b. Did tobacco use contribute to the cause of dear										
								_	1 105 20 140	0 710		
v requir								24e. We per	s en eutopsy formed?	ev	ere eutopsy findings eilable prior to mpletion of cause death?	
f Vital Recystolen: The law ystolen: The law is certilicate has director, pege 2 fo Be Comp								1,2	Yes 2□No	1,1	Yes 2□ No	
of Vital I Physician: The This certificate and director, per		Hospital:		37		Oth	0.00	Death (Check only				
- S 00 L	27. Menner of Deeth 1 Naturel 5 Pending 2 Accident investigation	28e. Deta (Mo	e of Injury enth, Dey Year)	28b. Time of Injury	-	28c. Injur Wor	4 🗆 IAUISIN	& PARTIA	how injury occu	rred SUB	DECT HAD SEL COMPROMIS	
Division of To the Hospital or Attending Phywithin 24 hours eiter death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 7	3 Sulcide 6 Could not to determined	28e. Pled	ce of Injury - At h ding, etc. (Speci	ome, ferm, str fy) RESI[y, office		281. Location City or T		per38 Burg	TREE Number,	
To the Hospital within 24 hours To the Funeral I completely filled	29a. Cartifier 1 Certifying Pl	miner: On the	ne best of my kno basis of examine onner stated.	owledge, deeth etion end/or In	n occurred vestigetion	et the tir , In my c	ne, dete and ple plnion, deeth o	ece, end due to th	e ceuse(s) and m	nenner es s , end due t	teted. the ceuse(s)	П
To the He within 24 To the Fe complete	29b. Signeture end title of certifier		1	,	29		e number		29d. Dete sign			
	atust.	1 1	lac	15,M	P		C.M.E		FEB.	4, 19	77	
N	30. Name and address of person who	completed cer	use of deeth (Ite	11 Peni	n Str	eet,	Baltim	ore, Mary	land 21201			
State	31. Date filed (Month, Day, Year)	Cauci	Registrer's Sign	eture	do							
Registrar	0 13	100	1	D.	10	a M	/					



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Daath 3. Tima of Death **Physician** Month William Blake Eason February 09 1999 /Medical 4a. Facility Nema (If not Institution, give straat and number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** Chestertown
If Under 1 Year | If Undar 24 Hrs. | 8. Data of Birth
Months | Days | Hours | Min. | (Month, Day,
Algust 5, The Kent & Queen Anne's Hospital Inc. 5. Social Security Number 7. Aga (In yrs. lest birthday) Sax 120M 2□ F Birthplaca (State or Foreign Country) **Funeral** 217-30-9434 65 Yrs. **Director** Wilmington, DE Usual Rasidanca of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f shov traumatic event, the Manical Examenae must be notified at 1 Yes 2 □ No Directo Maryland Kent Chestertown 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? filed within 72 hours efter death with 416 Duke of Kent Street 21620 USA Funerai 12. Was Decedani Evar in U.S. Amged Forcas? 12. Was 2 □ No If Yas, Giva Yaar or Dates: 1952—1978 Was Decedant of Hispanic Origin? (Spacify Yes or No-If Yes, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Spacify only highast grada completed) 18e. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry Elamantary/Secondery (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mentel Hygiene. Important: If Item 27 Is marked other than any injury or other traumetic event College (1-4or 5+) Chief Master Sergeant Military 17. Fethar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Melden Sumama) Fredrick Becker Eason Mary Maude Stevens 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Rebecca Eason/Wife 416 Duke of Kent Street, Chestertown, MD 21620 20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 1 Buriel 2 Cremetlon 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Spacify) Chesterfield Cemetery 2/13/99 Centreville, MD 21. Signetura of Fyneral Sarvige Licen 22. Name and Address of Fecility Fellows, Helfenbein & Newnam Funeral Home, P.A. moo 93/130 Speer Road, Chestertown, MD 21620 that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrast, cause on each line. **Physician** Immadiate Ceusa (Final disaase or condition rasulting in deeth) /Medical Examiner Failure To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours elder death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the stuneral director, page 2 should be deteched for use as the burial-transit Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaase or Injury that initiated events rasulting in daath) Last Division of Vital Records, P.O. Box 68760 pura tem Po Dua to (or as a consequence of): Physician/Medical Cancinona Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 PYes 2 No 3 Probably 4 Unknown to Brew Arguse, Alcoline Arguse in prest. þ 24b. Wara autopsy findings evelleble prior to complation of ceusa of deeth? Completed 24a. Was an autopsy 1 Tyas 2 No 1 □ Yas 2 □ No 25. Was cese refarred to medical examinar? Be 26. Pleca of Death (Check only ona) Hospitel: 1 Inpatiant 2 ER/Outpatient 3 DOA 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Certification: To 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Panding mil Investigation 1 TYas 2 TNo 2 Accidant 6 Could not be dataminad 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 3 Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide Medicai 29a. Certifier 1 Certifying Phyalcian: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated. 2 Medical Examinar: On tha basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceusa(s) and manner stated. 29b. Signatura emittila of certifier 29c. License number 29d. Date signed (Month, Dey, Yaar) 123889 12 + 30. Name end address of person who complated ceuse of death (itam 23a) (Type, Print) 948 WAShing for Ave, efferten four, Med 21620 JOHN C. ARRABAL 1 m, mis. 31. Date filad (Month, Day, Yaar) 32. Registrar's Signatura State FEB 12 Registrar

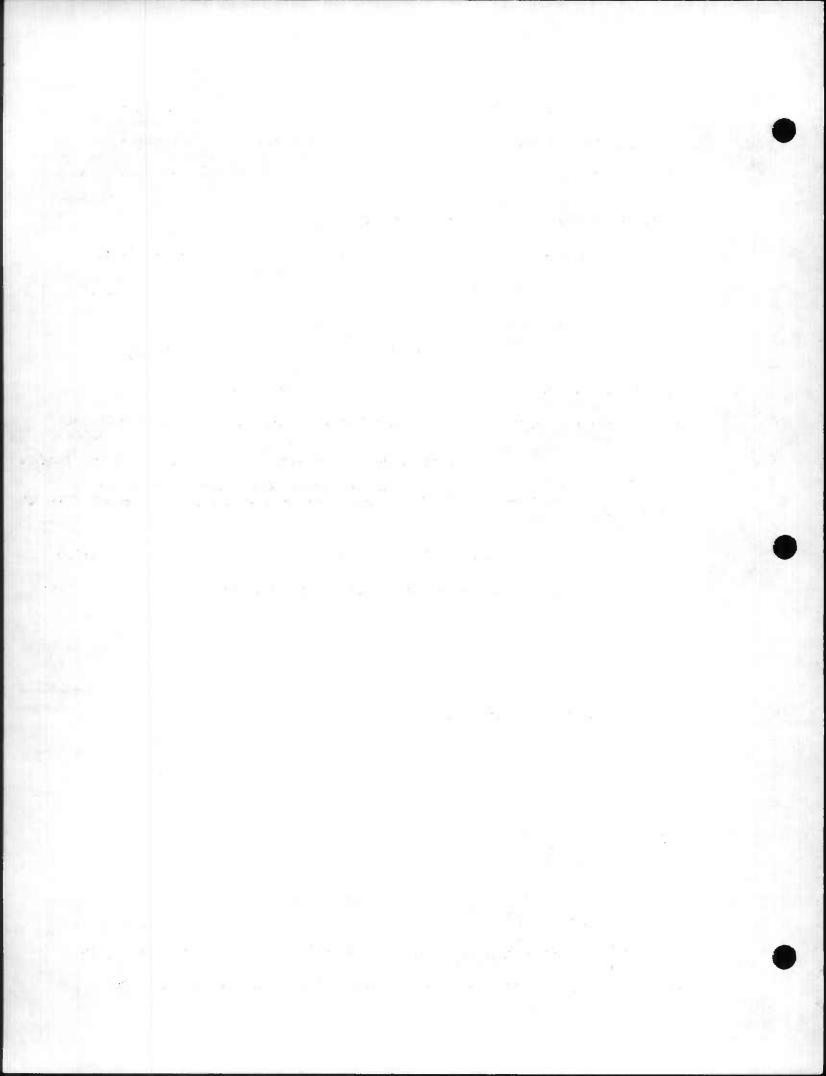


State of Maryland / Department of Health and Mental Hygiene 9 0539

				Certi	ficate o	f Death	7	F	Reg. No.		
	1. Decedent's Neme (First, Middle, L	ast)						2. Dete of Dee			3. Time of Deeth
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/Medical Examiner	4e Fecility Neme (If not institution, gr					4b. City, T		cation of Deeth			J. LO III
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Funeral Director	155-36-2280	1□M 2対F		Yrs.	Months Dey		Min.	Nov 17	, Year) 1902	Country Marvla	ce (Stete or Foreign y) and
	Usuel Residence of Decedent							1			
M 1	10e. State 10b. County		10c. City, Town	or Local	tion					100	d. Inside City Limits
items 23s or 28s-f show instructs be nouned at Tuneral Director	Maryland Montgome	rv	Silver	Spri	ing						1 ☐ Yes 2X No
be nour ad Director	10e. Street end Number			- 1	10f. Zip Code	A		1	10g. Citizen of	Whet Country	v?
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20 00	14400 Homecrest	12. Wes Decedent	Ever in H.C	12 18/0		f Hispania O	rialo 2 (Coo	cify Yes or No-		e - American	
Funeral	11. Meritel Stetus	Armed Forces?		If Y	es, specify C	uban, Mexica	an, Puerto I	Rican, etc.)		ck, White, etc	
by F	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 I	No	10	JYes 2∭ N	lo Specify	y:		Specif	y: White	2
Q Q		Yeer or Detes:	1 72						101 101 1 10	.1	
ete	15. Decedent's E (Specify only highest g	ducation rede co <i>mpleted)</i>	16e.	(Give kin	nt's Usuel Oct and of work doi NOT use ret	cupation ne duning mo	st of working	ng	16b. Kind of B	usiness/indu	stry
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CO		5+	L:	ibraı	rian			-	Libra		
Be	17. Fether's Neme (First, Middle, Las								Meiden Sumer	ne)	
10	Nathan Billstei	n				E1	1а Му	ers			
	19e. Informent's Name/Relationship	(Type, Print)	19b.	. Mailing	Address (Stre	eet end Numi	ber or Rura	l Route Numbe	er, City or Town	Stete, Zip C	iode)
	Sarah Byrne / Da	ughter	3 .	James	s Sprin	ng Cou	rt, R	Rockvill	le, Mar	yland	20850
	20e. Method of Disposition		20b. Plece of	Dispositi	ion (Neme of	nlece) —		Date	20c. Location	- City or Town	n, Stete
	1 Burial 2 Cremetion 3 Other (Spec		Coto	of U	tory or other p	Feb	. 6,	1999	Silver	Sprin	g, Maryland
۵	21. Signature of Funeral Service Lips		Gate (leme end Ad				DIIVEL	PPLIN	5, raryraid
once.	1011	1300		Robe	ert A. I	Pumphrey	y Funer	ral Home,	/Rockvil	le, Inc.	•
	Kont Je		M00198	300	West M	ontgomer	ry Aver	nue, Rock	cville, M	laryland	20850-2805
	23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused one ceuse on each li	d the death. Do n	not enter t	the mode of o	tying, such e	s cardiac o	or respiretory er	rest,	A	Approximete nterval Between
in T											Onset end Deeth
al	Immediate Ceuse (Final disease or condition	Myoc	ardial :	Infai	rction					S	udden
er	resulting in death)	е. 11900	Due to (or es e							0	
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Ē		b. Alte	Due to (or es a d			TOVASC	ulai	Disease	2	1 1	0 lears
Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying		200 to (01 03 d (Jupania	317.						
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edicai	resulting in deeth) Lest		Due to (or es e c	onseque	nce of):						
3		d									
Physician	Day Ottal			.1						an Andrew A	h
ysi	Pert II. Other eignificent conditions	contributing to death b	out not resulting in	the unde	erlying cause	given in Pert	t I.				the cause of death?
	Chronic Obstru	ctive Pulm	nonary D	isea	se			10	Yes 2□ No	3 Proba	ibly 4⊠ Unknown
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m	examiner?	Hospitel:	on one	dandinat	2004	Other				has /Crasit it	
. To	27. Menner of Deeth	1 U Inpatie		tpetient ime of	3LI DOA	4 621 1			denca 6 Ott		
o	1 Neturel 5 ☐ Pending	28e. Date of Inju (Month, De	y Year)	njury		njuryat Work? □ Yes 2 □					
cat	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not	he						OPE Location "	Otropt and Al	horor Durell	Pouto Number
Certification:	4 Homicide determine	200. Flaca 01 III	jury - At home, fa c. <i>(Specify)</i>	rm, street	t, fectory, offi	C8		28f. Location (S City or Tox	Street end Num vn, Stete)	Der or Hure∏	noute Number,
edicai	(Check only 2 Medical Exa	hysician: To the best miner: On the bests of									
	one)	end menner st			,						
Σ	29b. Signature and title of certifier	110			29c. Lice	ense number	•		29d. Date sign	ed (Month, De	ey, Year)
	1.00	XX m	10 6 11	-	D07	471			Februar	у 4. 1	999
	30. Neme end eddress of person who	completed cause of d	leeth (Item 23a) (Lebiudi	7 79 1	
			'			207 1	Do 01	411a W	ov.1 1	20050	1200
	Paul T. Noone, M		er's Signeture	ת חנ	IVE, #	20/, 1	KOCKV.	ттте, М	aryrano	20002	-1790
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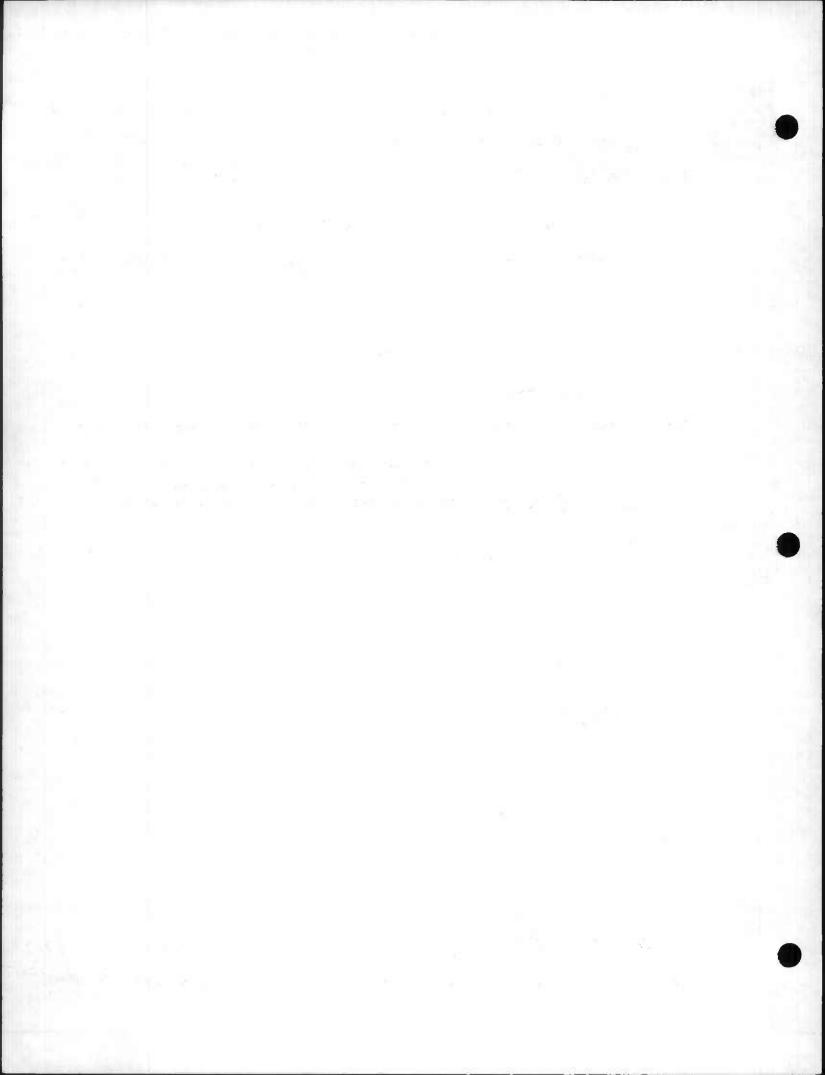
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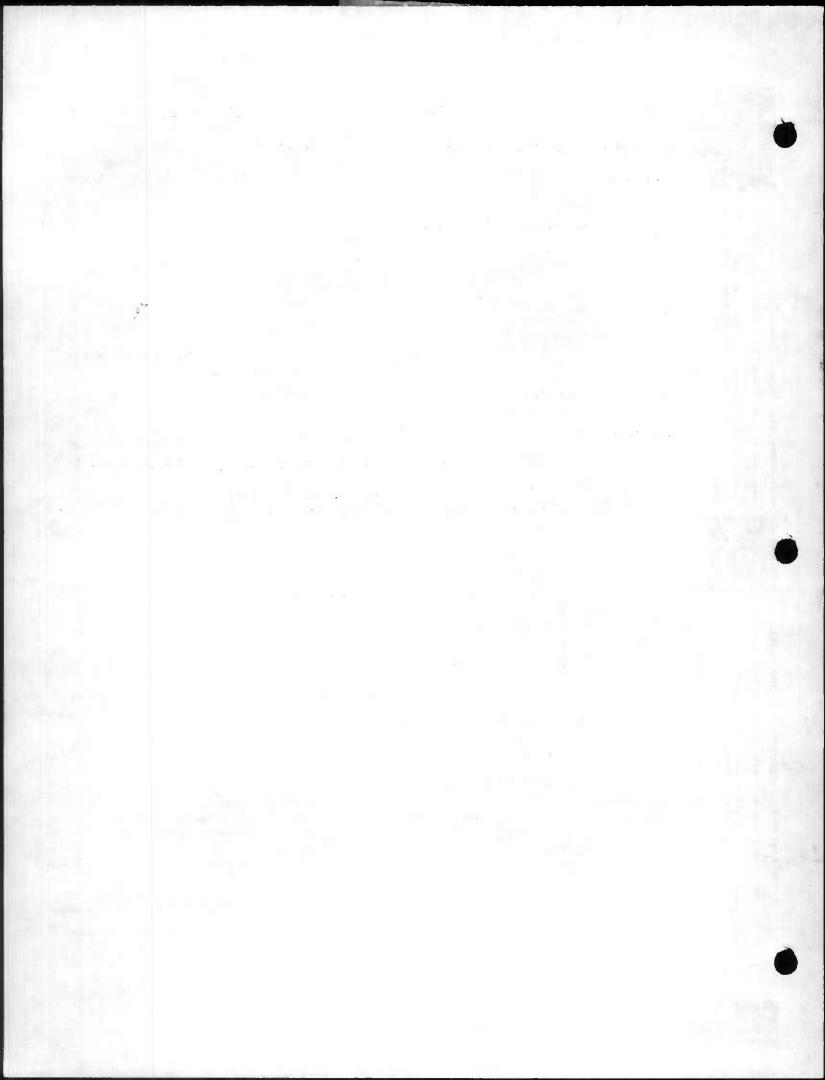
State of Maryland / Department of Health and Mental Hygiene 0.0

		1. December 16 Name /First 1 Eddie	I and		Cei	rtificate of	Death		Reg. No.		
Physici	an	Decedant's Name (First, Middle,						2. Dete of De Month	Dey	Yeer ,	Time of Death
/Medi			Helen M.	Epple				FEBRUA			305
Examir	ner	4a. Facility Nema (If not institution,					4b. City, Town, or L				
		Shady Grove					Rockvil		Monto	omery	7
Funeral		5. Sociel Security Number	6. Sex 7. Ag	e (In yrs. lest b		If Under 1 Yaar Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De	th ey, Year)	9. Birthplece Country)	(Stete or Foreign
Director		125-36-3389	10 111 221	91	Yrs.			December	20, 1907	New	
		Usuel Residence of Decedant 10e. Stete 10b. County		10c. City, To	um er l o	nation				1.01.	
sho a	-	Too. County		Toc. City, To	WII OI LO	cation					nsida City Limits
100	Sct		gomery			Gai	thersburg				X Yas 2 No
or 2	5	10e. Street end Number				10f. Zip Coda			10g. Citizen of Wi	het Country?	
23a	10	211 Russell	Avenue #60	00			20877		Unit	ed Sta	tes
ine. Then "natural", or items 23s or 28s-f show the Medical Examination must be notified a	ine	Maryland Montgomery Gaithersbur							- 14. Race	- Amaricen Ir Whita, atc.	idien,
or it		1 ☐ Nevar Marriad 2 ☐ Marrie				1 ☐ Yes 2 🐼 No		riioari, oto.,		, willia, atc.	
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d other i	Bec	17. Fethar's Name (First, Middle, L.	ast)	,				e (First, Middle,	Maiden Sumeme		
	To B	Walla	ice Post					Receie	Snedeker		
	-	19e. Informent's Name/Relationshi		19	b. Mailir	na Address (Street	end Number or Rur			itete. Zip Cod	(a)
tra tra		Nancy J. Varney/									
9 5 5		20e. Method of Disposition	Daugnter	20b. Place	of Dispo	sition (Neme of	Street R	Date	20c. Location - C		
- m		1 ☐ Burial 2 K Cremetion	3 Ramoval from State	cemet	ery, cren	metory or other ple	∞) February	10, 1999	200. Eddanon - C	nty or rown,	31616
tant		4 Donetion 5 Other (Spe		M	onte	gomery Cr	ematorium	Inc.	Bethes	da, Ma	ryland
Dependent Important: If any Injury or once.		21. Signeture of Funaral Service Li	Funeral Home/Rockville, Inc Avenue Rockville, Maryland2								
.O. E. a. a.		1/2 ()/									
		23a. Part1. Enturne disease, or o shock, or haert failure. Little	or plications that ceused							App	roximate
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/Medical		Immediete Ceuse (Final diseesa or condition	(px	ohna	INA	colon	Aci de	ul		4	-DAYS
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g physician and as the burial-trensit	Examiner	Sequentially list conditions	b	Due to (or es	consen	manca of).				1	
ial-tr	EX	Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Ceuse (Disease or Injury			1						
sicia e bu	edicai	thet initieted events			1						
CD OIL	p	resulting in death) Last Dua to (or as a consequence of):									
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y the ettendin ached for use	Physician/N	Death Observation Was a series									
ed by the e detached f	ıysi	Part II. Other significant condition	s contributing to death bu	ut not rasulting	in the ur	nderlying cause gi	an in Pert I.		tobecco use cont		
deta deta		(type	rtensio	n				10	Yes 2□ No	3 Probably	4 Munknov
5.8	d by							24a Mac	en eutopsy	24h Wara a	utopsy findings
been si	ete								rmed?	evelleb	e prior to tion of cause
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pa	S							10	Yes 2⊠No	1 🗆 Ya	s 2□ No
s certificate director, pag	Be	25. Wes case raferred to medical exeminer?					26. Plece of Deet	h (Check only o	one)		
0 0	To	1 ☐ Yes 2 No	Hospital:	nt 2 ER/C	Outpetien	nt 3 DOA Oth	ner: 4 Nursing Ho	ma 5 ☐ Resi	denca 6 Other	(Specify)	
		27. Menner of Daeth	28a. Dete of Injur (Month, De)	ry 28b.	Time of	28c. Inju	y at	28d. Describe	how Injury occurre	d	
r death. sctor: After t by the funera	를 들	1 Naturel 5 ☐ Pending 2 ☐ Accident investiga		y rear)	Injury		Yes 2□No				
r death.	HICK	3 ☐ Suicide 6 ☐ Could no	286. Place of Inti	ury - At home,	ferm, str	eet, factory, offica		28f. Location (Straet and Number	r or Rural Ro	ute Number,
efter death Director: / d in by the	Certification:	4 Homicide	building, efc	c. (Specify)				City or To	wn, Stete)		
24 hours e Funeral L etely filled		29a. Certifier 115 Certifying	Phyelclen: To the best of	of my knowledg	na daeth	occurred at the ti	me date end pleca	end due to the	cousa(s) and man	nar as statad	
C 16 %	edicai		xaminer: On the basis of end mennar sta	exemination e	nd/or inv	vestigation, in my	ppinion, death occur	red et the time,	dete end placa, er	nd due to tha	cause(s)
Fun etely	Me	29b. Signetyre end titla of certified	dame			29c. Licans		T	29d. Date signed	(Month, Dev.	Yeer)
ithin 24 h o the Fu		Mucustall	- acreer	4 0				1	201140	V AC	100
within 24 hours efter of To the Funeral Direct completely filled in by			111111111111111111111111111111111111111	7 4 6 10	0	NIO 1	15011 -	77	PULLATO	1 117	177
To the Fur		Vue -	7/1	privo	7	1-40 -		(-		. 0 ,	
To the Function 24 to completely		30. Nema and address of parson w			Туре,	Print)	2015 - (F 1	20 this	286	110020
within 24 P		30. Nema and address of parson with the control of	SAXENA	aath (Itam 23a)	De	Print) Per Cvo)301/2 m ing (+ 1	Between	236	nu)21



			•	Department of I Certificate of			Reg. No.	05392					
Physician	Decedent's Nama (First, Midd	a, Last)	F			2. Date of De Month	Day \	3. Time of Death					
√ /Medical	Hughes 4a Facility Name (If not Institution	a aire street and number	Exum		4b. City, Town, or I	Februar	-						
Examiner	March Principles and Authorized				Takoma Pa		Montgo						
	Washington Adv		ge (In yrs. last biri	thday) If Undar 1 Year				9. Birthplace (State or Foreign					
Funeral Director	358-16-5542 Usuel Residence of Decedent	1□M 2∏F		Yrs. Months Days	Hours Min.	8. Data of Bir (Month, Da July 29	y, Year) 9, 1913 M	Country) ississippi					
and the state of t	10a. Stata 10b. County		10c. City, Town	n or Location				10d. Inside City Limits					
with the Maryland a or 28s-1 show the notified at	Maryland Mont	gomery	Silver	Spring				1 ☐ Yes 2 🔀 No					
or 28a	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	nat Country?					
th with	9708 Mt. Pisga	ah Lane, #20	1	20903	3		United S	tates					
0020 hours after deeth with the Mar turel, or items 23e or 28e-1 si Examiner must be notified at by Funeral Director	11. Marital Status 1 Naver Married 2 Mar 3 Naver Married 4 Divorced	If Yes Give	? [No	13. Was Decedent of If Yes, specify Cub		pecify Yes or No o Ricen, etc.)	04	- Americen Indian, Whita, etc. Black					
5-00; 72 hours naturel; pical Ex	15. Deceder	it's Education st grade complated)	16a.	Decedent's Usual Occu	pation	tkina	16b. Kind of Busi						
1 21215-0020 ed within 72 hours af vyglena. The than "natural", or it, the Medical Exam	Etementery/Secondary (0-12)	College (1-4or		(Give kind of work done life. DO NOT use retire	ed)		Denartme	ent Store					
	17. Fathar's Name (First, Middle,	Last)		ook	18. Mother's Nar	ne (First, Middle	, Maiden Sumame						
yland build be fill Mentel H Mentel of attice of a stice	zpatrick			Cassina	Evans								
E SEE	19a. Informant's Name/Relation	•	19b	. Mailing Address (Stree			er, City or Town, S	tate, Zip Code)					
CENL	Beatrice Hann	ible (daught	ter) S	ame as 10									
5 - E E	20a. Method of Disposition		20b. Placa of	Disposition (Name of y, crematory or other pla	ace)	Date	20c. Location - C	ity or Town, State					
altimore, mit. Peges 1 er pertment of Haa portmet: if Nem.; y Injury or other	1 🗷 Burial 2 🗆 Cremation 4 🗆 Donation 5 🗀 Other (5		8	wn Memoria		2-8-99	Pinelawn	, New York					
Baltimo permit. Peges Department of Important: If I	22. Name and Address of Facility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that ceused the beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate												
	23a. Part1. Entar tha disaasa, o shock, or heart failure. Lis		Approximata tntarval Between Onset and Death										
Physician /Medicai Examiner	Immediate Cause (Final disease or condition resulting in deeth)	Pn	semon	10				S					
N 2 2		- acel		consequence ot):	011	failer	e	5					
8760, cete be axecuted physician and the burlet-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated avents	Back	Due to (or as a	consequence of):	illere	3		5					
Shys the	resulting In death) Last												
death cert death cert de ettendin de for use	Part II. Other significant conditi	ons contributing to death	but not rasulting Ir	n the underlying ceusa g	ivan in Part I.	23b. Did	tobacco use cont	ribute to the cause of death?					
is, P.O. Box 6 as that the death certifi igned by the ettanding be detached for use as by Physician/Me	CXZ	essive		SIG -		1 🗆	Yes 2□ No	3 Probably \d⊒U nknown					
ord requir		stage		rentia		24a. Was	s an autopsy ormed?	24b. Were eutopsy findings available prior to completion of ceuse of death?					
Tha law ate has bege 2 s		e12-10				10	Yes all No	1 ☐ Yes 2 ☐ No					
ystelan: The ystelan: The secretificate director, peg		ıl.				ath (Check only	one)						
Of Vita Physician: This certific and director, To Be	1□ Yes 2□ No	Hospital: 1 Dear		itpatient 3LJ DOA			idence 6 Othar	11111					
Vision C Attending Pt in death. ector: Atter it by the funera		gation	jury Je <i>y Year)</i> 28b. 1	Fime of 28c. Injury Wi	uryat ork?]Yes 2 ☐No	28d. Describe	how injury occurre	d					
Divis	3 ☐ Suicida 6 ☐ Could 4 ☐ Homicide deten	not be nined 28e. Place of la building, s	njury - At home, fa etc. <i>(Specity)</i>	rm, street, factory, office		28f. Location City or To	(Street and Number wn, State)	r or Rural Route Number,					
Division o To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one)	ng Phyalcian: To the bes Examiner: On the basis and mannar	of examination an	d/or Investigation, in my	opinion, death occu		, date and place, ar	nd due to the cause(s)					
Total Com	29b. Signature and title of certific			D C	A// C 2		29d. Date signed	(Month, Day, Year)					
	30. Name and ddress of person	who completed ceuse of	death (Item 23a)	(Type, Print) V Dyiv	e 6	't can	mo:	20874					
State	31. Date filed (Month, Day, Year	4	strar's Signature	4. Spork	2								
Registrar	FEB 0 8	1999	1	. popour									

DHMH 16 Rev 6/95



SR.

FLEMING,

Certificate of Death

1. Decedent's Name (First, Middle, Last)

CURTIS

The Memorial Hospital

4a Fecility Name (If not institution, give street end number)

CLYDE

Physician

/Medical

Examiner

Reg. No. 3. Time of Deeth

Day Yeer Month

2. Dete of Death 4:24 PM

February 6,1999 4b. City, Town, or Location of Deeth 4c. County of Death

Talbot

Birthplace (State or Foreign Country)

MARCH 9,1921 TEXAS

10d. Inside City Limits 1DIYes 2□No

Specify:

10g. Citizen of What Country?

USA Race - American Indian, Black, White, etc.

WHITE 16b, Kind of Business/Industry

Easton

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

P.O. BOX 146, WYE MILLS, MD 21679

20c. Location - City or Town, State CHESAPEAKE CREMATION CTR. 2-8-99 STEVENSVILLE, MD

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.

Approximete Interval Between Onset and Deeth

DIBBASK

PULMONNY DESER YOU

4000

23b. Did tobacco use contributa to the causa of death?

1 Yes 2 No Probably 4 Unknown

24b. Were autopsy findings available prior to 24a. Was an autopsy

minutes

completion of cause of death?

1 Yes 2ZTNo

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (IJem 23e) (Type, Print)

32. Registrar's Signature

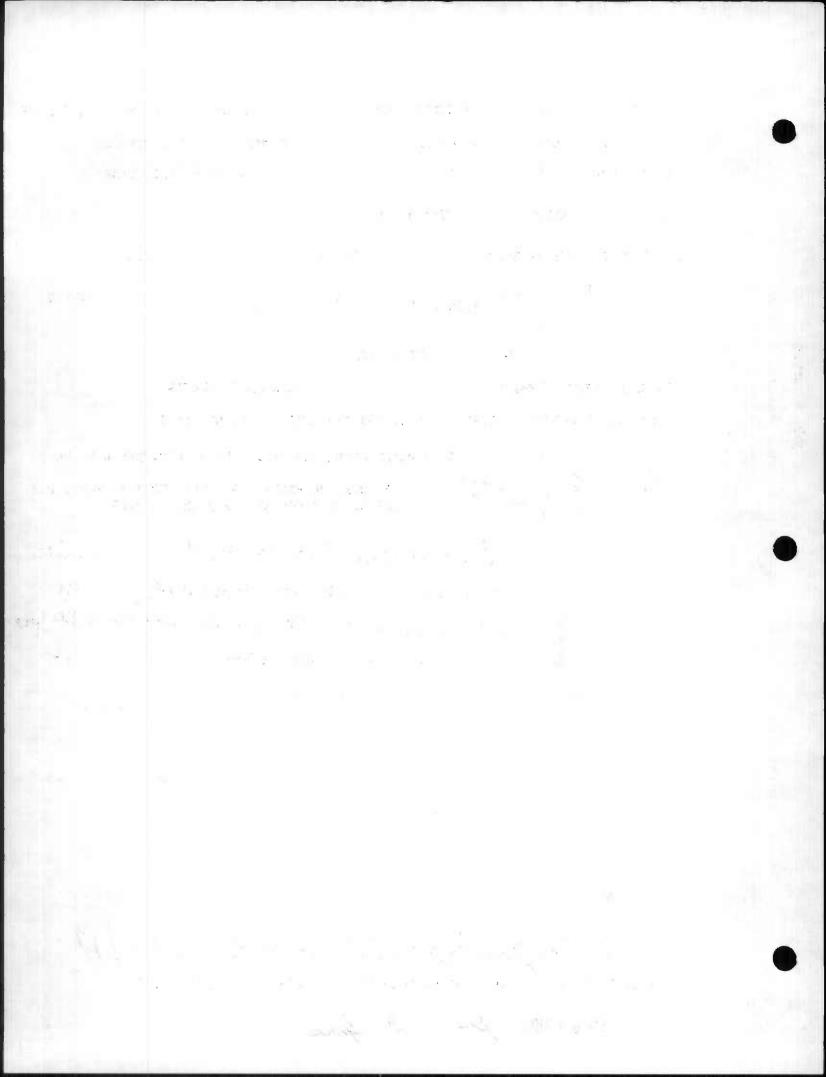
ERIC F. CIGANEK, M.D., 109 S. COMMERCE ST., CENTREVILLE, MD 21617

Registrar

31. Date filed (Month, Dey, Year)

peners G. Sports

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) FEBRUARY 1 9999 **FEDERLINE JOSEPH** 1:50 PM ALLEN 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Pooks Hill Road, Apt. 907 Bethesda Montgomery 9. Birthplace (State or Foreign Country) Maryland if Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) May 31 1926 5. Social Security Number 7. Age (In vrs. last birthday) if Under 1 Year Months Deys 1 M 2□ F Hours 577-34-4800 72 Usual Residence of Decedent 10c City Town or Location 10d Inside City Limits 10b County Bethesda Montgomery 1 □ Yes 250 No Maryland 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20814 3 Pooks Hill Road, Apt. 907 13. Was Decadent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U.S. Armed Forces? Rece - American Indian, Black, White, etc. 11 Maritei Status 1 RYes 2 No 1944-if Yes, Give Yeer or Dates: 1946 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Carpenter U. S. Government 18. Mother's Name (First, Middle, Meiden Sumame) 17. Fether's Name (First, Middle, Last) Federline Louis Minnie Kramer 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Allen M. Federline / Son 216 Rolling Road, Gaithersburg, Maryland 20877 20b. Place of Disposition (Neme of 20c. Location - City or Town, State 20a. Method of Disposition cometery crematory or other plece) St. Mary's Cemetery 1 → Burial 2 Cremetion 3 Removal from State 2/10/99 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licanses 22. Name and Address of Facility Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Maryland 20882 23a. Part 1. Ent ... Lie _____sease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate triterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Die to (o) as e consequenca of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or as a consequenca of): Due to (or as e consequence of) Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause ot death? 24a. Was an autopsy 1 ☐ Yes 2 No 2 No 1 Yes 25. Wes case referred to medical 26. Piece of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

10e State

Directo

Funerai

þ

Completed

Funeral

Director

permit. Pegas 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, it a Medical Example mass.

Baltimore, Maryland 21215-0020

Examiner Physician/Medicai þ Completed Be 2 Certification:

examiner

1 Yes 2 No

Menner of Deeth

Natural

Accident

4 Homicide

3 ☐ Suicide

29a. Certifier

physicien and the buriel-trensit attending p signed by the a been si has 9 2 irector, page 2 director, this funeral After

after death.

Director: A within 24 hours aft To the Funeral Di complataly filled in

The law requires that the death certificate be axecuted Records, P.O. Box 68760, To the Hospital or Attanding Physician: death.

Division of Vital

State Registrar

Medicai

29b. Signature and title of certifier

28e. Dete of Injury (Month, Dey Year)

1 ☐ inpatient 2 ☐ ER/Outpetient

28b. Time of

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

28c. injury at Work?

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and place, and due to the ceuse(s) and manner es steted.

Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and menner steted. 29d. Date signed (Month, Day, Year) ebruary

281. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residenca 6 Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed co Pike, #348, Rockville, MD ille atricia 10m 31. Date filed (Month, Day, Year)

3 DOA

FEB 08

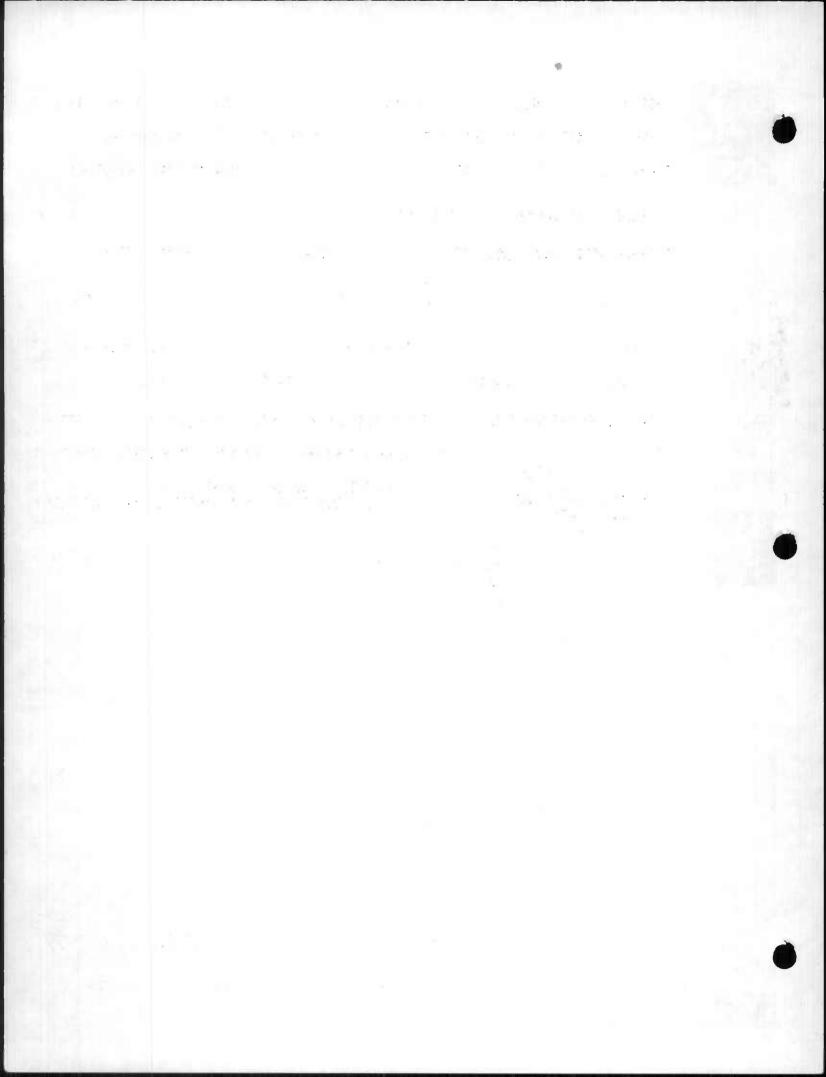
5 Pending

Investigation

6 Could not be determined

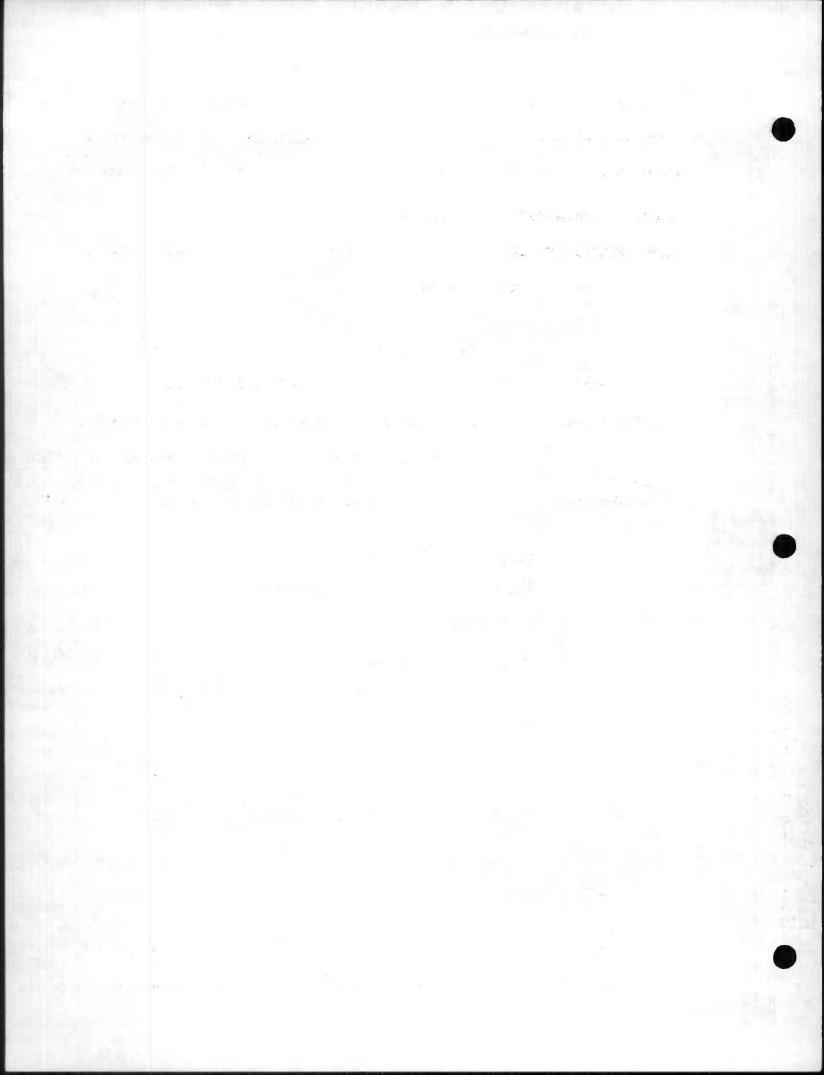
32. Registrar's Signature

t 0



State of Maryland / Department of Health and Mental Hygiene

				Ce	rtificat	e of	Death			Reg. No.				
	1. Decedant's Name (First, Middla, L	ast)							2. Data of De Month	ath Day	Yaar		e of Death	
Physician /Medical	AARON FE	IBEL							FEBRUA	RY 7,	, 1999		25 PM	
Examiner	4a Fecility Name (If not institution, g SUBURBAN HOSPI		ber)					IESDA		N	County of De			
Funeral Director	5. Social Security Number 6. 056-12-5135	Sax 1☐M 2☐F	'. Aga (In yrs. ia 78	st birthday) Yrs.	Months Months	1 Yaer Deys	If Undar Hours	24 Hrs. Min.	8. Dete of Bi (Month, Di OCT 2	th y, Year) , 192	9. B 20 NI	irthplaca (Sta Country) EW YOR	ta or Fora K	
show id at	Usual Rasidance of Decedent 10a. State 10b. County		10c. City,	Town or Le	ocation					10d. Inside City Limit				
28a-f sho notified at	MARYLAND MONTGO 10e. Street and Number	MERY	PO	TOMAC	10f. Zlg	Code				10a Citiz	zen of Whet C		es 2∭	
23a or	12909 MISSIONWO	OD WAY		20854								STATES		
by	11. Marital Status 1 Navar Married 2 Married 3 Widowad 4 Divorced	Armed Ford	POWW I		Was Dece il Yes, spe 1 ☐ Yes	cify Cub	an, Maxicer	lgin? (Spe n, Puarto	Rican, etc.) Black			narican Indiar nita, atc. HITE	١,	
natur solical leted	15. Decedant's l (Specify only highast g	ducetion rada complated)		16a. Dece (Giva	dant's Usu kind of wo DO NOT u	el Occup ork dona	pation during mos	t of worki	ing	16b. Kir	nd of Businas	s/Industry		
it, the Medical in Completed	Elementery/Secondary (0-12)	College (1-	4or 5+) 5+		ORNEY						TAX			
d off	17. Fether's Nama (First, Middla, Las MORRIS FEIBEL	<i>t</i>)							ROTHEN		Sumema)			
EĘ	19a. Informant's Name/Ralationship	(Type, Print)		19b. Maili	ing Addres	s (Straa	t and Numb	er or Rura	al Routa Numb	er, City or	r Town, Stata	, Zip Coda)		
NF	LILLIAN FEIBEL	(1	WIFE)				MOOD	WAY	- POTO					
ury or other	20a. Mathod of Disposition 1 Buriel 2 Crametion 3 4 Donation 5 Other (Special Content of the C		tate	nce of Disper matary, cra H EL	matory or	othar pla	ace)	2	Date 2/10/99		RAMUS,			
any injury or once.	22. Name and Addrass of Fecility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MARYLAND 20852 23a. Part. Enter the disease, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, interval Batween the structure of the such as the such													
ettending physician and all for use es the buriel-transit all clan/Medical Examiner	Sequentially list conditions, if any, laeding to immediate ceusa. Enter Underlying Causa (Disease or injury that initiated avants resulting in death) Last	. Col	PDue to (or a	MC as a consa	quance of):		inor	Ma	P			ZO U	les Jea	
ed by the ettendin deteched for use y Physiclan/N	Part II. Other significant conditions	contributing to das	ith but not resul	ting in the u	underlying	ceusa gi	ivan in Part	l.	23b. Dic	tobacco	use contribu	ite to the cau	se of dea	
and by se detection of Physics									1 3	Yes 2	□ No 3□	Probably	4 🗌 Unkn	
sate has been signe page 2 should be d Completed by									24a. Wa perl	an autop ormed?	osy 24t	o. Were eutop eveilable pr complation of deeth?	ior to	
page page									1 🗆	Yes 20	12 No	1 🗆 Yas	2□ No	
director, pag	25. Was cesa referred to medical axaminar?	Hospital:	/		-5-	Ot	hor		h (Chack only		. 50			
5-3	1 ☐ Yas 2 ☑ No 27. Manner of Death	28a. Data ol		R/Outpatie 28b. Time o Injury		28c. Inju	4 L N	-	ma 5 Res 28d. Dascribe			oecify)		
within 24 nouts ener death. to the Funeral Director: After the completely filled in by the funeral Medical Certification:	1 Matural 5 Panding 2 Accidant 3 Suicida 6 Could not determine	be 28a. Place of	of Injury - At hor g, atc. (Specify)	na, larm, si	М	1 🗆	Yas 2		28I. Location City or To	(Street en wn, Stele	d Number or)	Rural Routa i	Vum <i>ber</i> ,	
Yo the Funeral Direct completely filled in by Medical Certifi		hysician: To the baseliner: On the baseliner	sis of axamination										se(s)	
comple	29b. Signetura and Mile of Contribut	- M	Л.		29	c. Lican	sa number	211		29d. Dat	a signed (Mo	onth, Day, Yea	ar)	
State	30. Name and address of person who T. Heler MD 31. Data filed (Mamb-Day, Yeer)	Subur	ol death (Item	pital	, Print) 8600	01	d be	reje	townR	1, 80	thesda	MD	208	



State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Feldmann. Kathryn Lillian February 6, 1999 1:40 PM /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Deys 1 □ M 2 🔀 F Yrs. Director 88 053-01-8430 Feb. 15, 1910 New York Usual Residence of Decedent the Marylend 10a. Stete 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinat must be notified at 10d. Inside City Limits 1 Tyes 2 No Director Maryland | Montgomery Derwood 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 17800 Mill Creek Drive 20855 United States deeth Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours effer neat of Healih and Mental Hydiane. mt. If item 27 is marked other than "natural", or ite ary or other traumate event, the Mental 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Teacher Education 17, Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Grace Frank DeMange Lillian 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 17800 Mill Creek Drive, Derwood, Maryland 20855 Richard J. Feldmann/Son 20b. Plece of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Depertment of Important: If any Injury or onge. 4 ☐ Donation 5 ☐ Other (Specify) 2/13/99 East Moriches, NY Mt. Pleasant Cemetery 22. Name and Address of Fecility DeVol Funeral Home 21. Signature of Funeral Service Licensee 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) e. Renal Failure 7 days Examiner Due to (or es a consequence of): Examiner b. Diabetes 30 years ettending physician end for use es the buriel-transit Hospital or Attanding Physician: The law requires thet the death certificete be executed 24 hours efter death. Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury that Initiated events resulting in death) Lest Due to (or as e consequence of) Box 68760, 10 years Mitral Regurgitation Physician/Medical Due to (or es e consequence of) 30 years Hypertension P.O. I signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown Atrial Fibrillation Records, þ been si 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed pege 2 s 1 Yes 2 XNo 1□Yes 2□No Division of Vital 25. Wes case referred to medical examiner? Be 28. Plece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Natient 2 ER/Outpetlent 3 DOA Medical Certification: To this funeral 27. Menner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After 5 Pending 1 Naturel s efter death.

i Director: After death.

id in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 I Homicide To the Hospital or within 24 hours eff To the Funeral DI Completely filled in 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

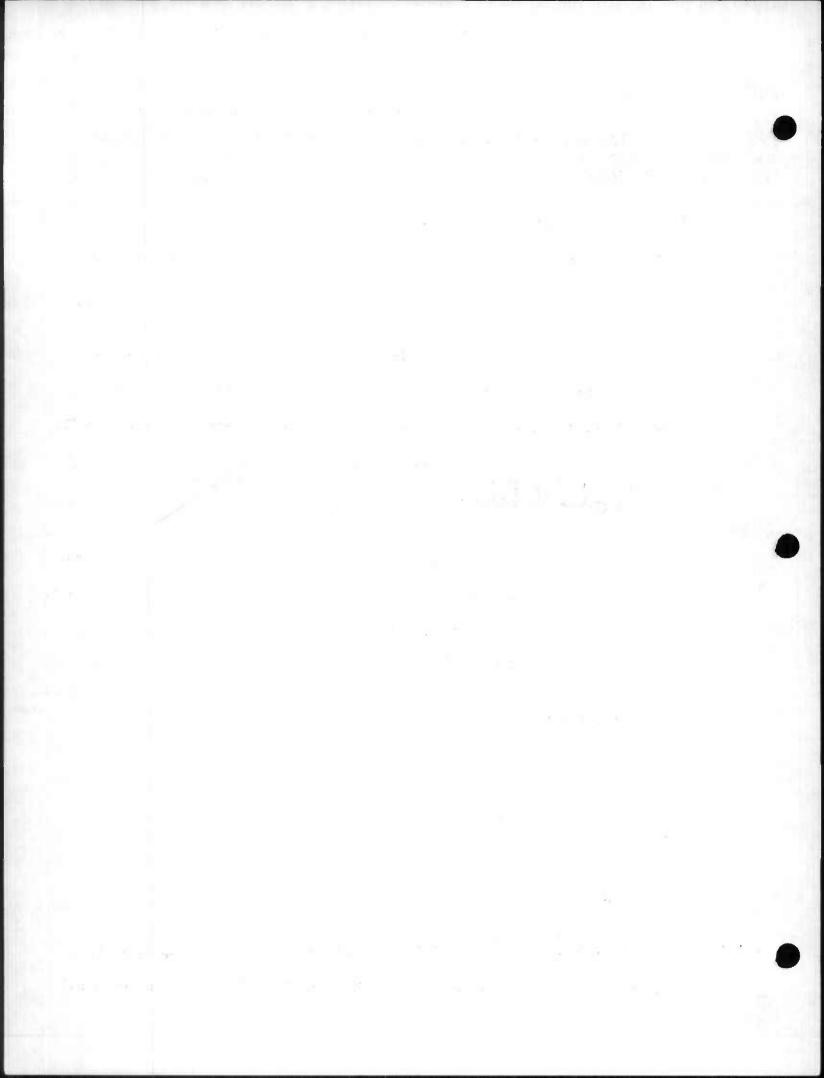
| Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated. 29a. Certifier 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) MD 3 D42777 February 7, 1999 30. Neme and eddress of person who completed ceuse of deeth (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year) FEB 0 9 1999

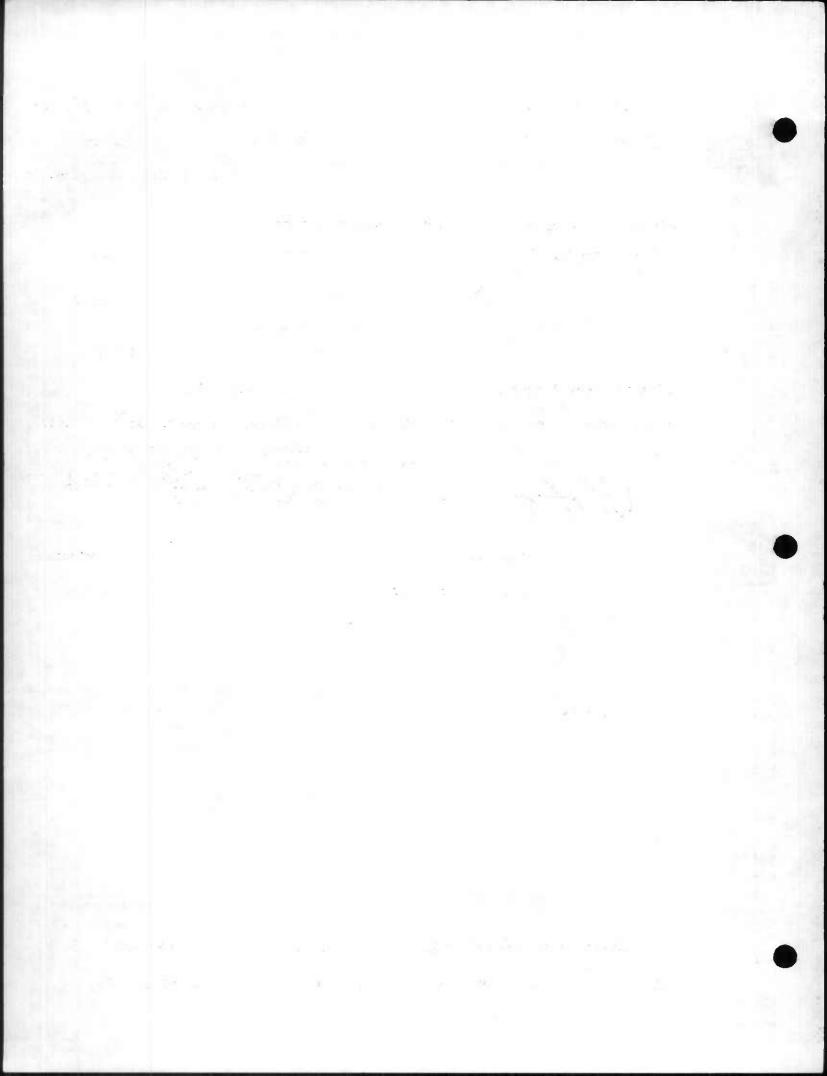
Richard I. Weinstein, M.D., 15225 Shady Grove Road, #201, Rockville, MD. 20850 32. Registrer's Signature



State of Maryland / Department of Health and Mental Hygiene 9 05397

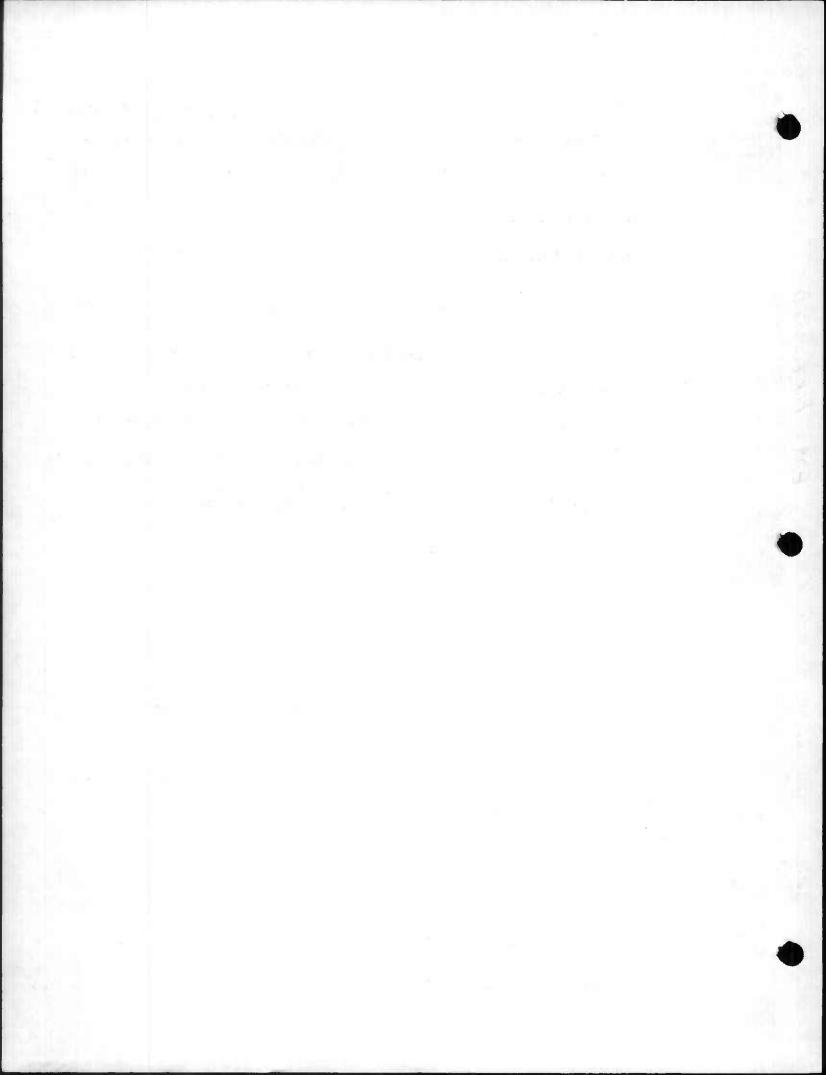
				Cer	tificate of	Death			Reg. No.		
	t's Neme (First, Middle, L	ast)						2. Dete of Do Month	eath Day	Year	3. Time of Deeth
sician edical	William R	oger Flah	erty					Februa:	ry 5, 1		5:55 AM
	Neme (If not institution, g	ive street end numb	per)			4b. City, To	wn, or Loc	cation of Dee	th 4c. County	of Deeth	
	9 Winterber	-					hesda			tgom	
lai		Sex 7. 1⊠M 2□ F	Age (In yrs. lest b	100	If Under 1 Yeer Months Days		Min.	8. Date of Bi (Month, D	rth e <i>y</i> , Yee <i>r)</i>		plece (Stete or Fore ntry)
	68-1176 denca of Decedent		49	Yrs.			1	Vovember	26, 1949	Wash	ington, D
	10b. County		10c. City, To	wn or Lo	cation						10d. Inside City Lim
10e. State Mary1 10e. Street 7809 11. Marital 1	36			Bethesda							1 ☐ Yes 2 🔀
Maryl	and Number	gomery			10f, Zip Code	nesaa_			10g. Citizen of	What Cou	ntry?
Mary1 10e. Street 7809 11. Marital 11 New New New New New New New New New New	Winterberry	Place				2081	7		United		
11. Marital		12. Was Deced	ent Ever in U.S.	13. V	Vas Decedent of f Yes, specify Cul			cify Yes or N			can fndien,
1 Ne	ver Married 2 Married	Armed Forc	es?				, Puerto F	Rican, etc.)	Bla	ck, White,	etc.
à 3□Wi	dowed 4 Divorcad	If Yes, Give Year or Date	••	1	☐ Yes 2 🔀 No	Specify:			Specif	y: W	hite
Element	15. Decedent's I	ducation	16	e. Deced	lent's Usual Occu	pation			16b. Kind of B	usiness/in	dustry
Q Flement	(Specify only highest g ery/Secondary (0-12)	rede completed) College (1-4	lor 5+)	life. L	kind of work done OO NOT use retir	ed)	t of workin	ng			
E	0	Gonego (1			Work	er			Wor	rksho	р
17. Fether's	Neme (First, Middle, Las	it)				18. Mothe	er's Name	(First, Middle	e, Meiden Sumer	ne)	
o Wil	lard Roger F	laherty				Mar	y Lo	uise E	nsign		
	nant's Name/Relationship		19	b. Mailin	g Address (Stree	et end Numbe	er or Rure	l Route Numi	ber, City or Town,	, Stete, Zi	o Code)
Willa	ard Roger F1	aherty/Fa	ther 7	809	Winterb	erry P	lace.	, Beth	esda, Ma	ryla	nd 20817
	d of Disposition		20b. Placa	of Dispo	sition (Neme of netory or other pl	eca) Tabas		Dete	20c. Location		
	rial 2 Cremetion 3 nation 5 Other (Spec				Heaven C			, 1999	Silver S Maryland		ıg,
	ire of Funeral Service Lig		oacc	22	. Name end Addr	ress of Facilit	v Robe	ert A.			neral Homonsin
	INH A	4	M01126	Be	thesda-Cenue, B	Chevy	Chase	e, Inc	., 7557	Wisc	onsin
23e. Part1	Enterthe disease, or co	mplications thet cau	used the deeth. Do	1						3301	Approximate
shool	, or heart failure. List on	y one cause on eac	ch line.							i	Onset end Deatl
	Ceuse (Finel	A d	. 4. 4							i	161
disease or resulting in	death)	e Aspira								1	Minutes
<u> </u>		D. 61.	Due to (or es]	17
Sequentiel if any, lead	hulist socialises	b. Kerre	Esophag							1	Years
if any, lead	ing to immediate		200 10 (01 43 1	J 00/1304	donoc 01).					1	
Ceuse (Distriction of the country of	ly list conditions, ling to immediate ter Underlying lease or Injury d events	C	Due to (or as e	conseq	uenca of):						
resulting in	death) Lest										
M/J		d								1	
Pert II. Other	er significant conditions	contributing to dea	th but not resulting	In the ur	nderlying cause o	iven in Part I	l.	23b. Did	I tobacco uee co	ontributa 1	to the cause of dea
F Down	ns Syndrome							10	Yes 2 No	3 □ Pro	bably 4 Unkn
bow.	is by narome						_				
8									s en eutopsy formed?	24b. W	Vere autopsy findin- vailable prior to
D e											ompletion of cause death?
Completed								10	Yes 2 No	1	☐ Yes 2☐ No
0 25. Was ca	se referred to medical					26. Plece	e of Death	(Check only	one)		
examin	er? s 22XNo	Hospital:	patient 2 ER/C	Outpatien	t 3D DOA	ther			sidence 6 Oti	her (Spec	ifv)
27. Manner		28e, Dete of	Injury 28b	. Time of					how injury occu		,,
1 DiNa	[acception 6]		Dey Year)	Injury		Yes 2	No				
3 □ Su	icide 6 Could not	d 266. Place o	f Injury - At home,	ferm, str	eet, fectory, office	9	2		(Street end Num.	ber or Ru	ral Route Number,
27. Manner 1 Tana 2 Ac 3 Su 4 Ho	4 ☐ Homicide building, etc. (Specify)										
		hysician: To the b	est of my knowledg	ge, deeth	occurred et the	time, date en	nd placa, e	end due to the	e cause(s) end m	anner es	steted.
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end placa, end du 2 Madical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date end placa, end du 2 madical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date end placa, end du 2 madical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date end placa, end du 2 madical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date end placa, end du 2 madical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date end placa, end du 2 madical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date end placa, end du 2 madical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date end placa, end du 2 madical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date end placa, end du 2 madical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date end placa, end du 2 madical Examiner: On the basis of exemination end/or investigation.									, date end place,	, and due	to the ceuse(s)
	29b. Signature and title of certifier 29c. License number								29d. Date signe	ed (Month	, Dey, Year)
	Jewi, h	Coli	4 MO		D	05256			Februa	ary 5	, 1999
30. Neme a	and eddress of person who	completed cause	of deeth (Item 23a) (Type,	Print)						
	N. Cahill,		00 Execu			ard. R	ockvi	ille.	Marvland	208	52
	ed (Month, Day, Year)		Istrar's Signature	1	-			,			
trar	FEB 0 9 1	999	eneral	Ø.	Sport						
	, 0 0 1		-	7	-						

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

					Ce	rtificate	of	Death			Reg. No.		
Discolate		1. Decedent's Name (First, Middle, Las	t)			11:1	П			2. Date of D Month		Yeer	3. Time of Death
Physicia /Medic		Eda Fortunato								FEBRU	ARY 8	1999	1145 AM
Examin		4a. Facility Name (If not institution, give								ocation of Dea	,		
		Doctor's Commun						Lanhai				e Geo	rge's
Funeral Director		059-05-9517	7. A	ige (In yrs. les 87	t birthday) Yrs.	If Under 1 Months I	Year Deys		Min.	8. Date of Bi (Month, D	28, 1911	9. Birthp Coun New	lace (Stete or Foreigr try) York
and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, 7	own or Lo	ocation						1	0d. Inside City Limits
f sho	6	Maryland Prince	George's	Mitc	hellv	ille							1 ☐ Yes 2 ☐ No
the 28a	Te C	10e. Street and Number	<u> </u>	11100		10f. Zip C	ode				10g. Citizen of	What Coun	itry?
23e or	ral Di	10450 Lottsford R	oad, #148	3		207	721				United		•
el', o	by Funeral Director	11. Marital Status 1 ☼ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Armed Forces 1 X Yes 2 ☐ If Yes, Give Year or Dates:	? No		Was Deceder If Yes, specify 1 ☐ Yes 20			gin? (Sp , Puerto	ecify Yes or N Rican, etc.)	o- 14. Rec Bla Specifi	ck, White,	
"natural",	Be Completed	15. Decedent's Ed (Specify only highest grad	ucetion de completed)	1	6e. Dece	dent's Usual (Docu done	pation during most	of work	ina	16b. Kind of B	usiness/Inc	dustry
han.	id I	Elementary/Secondery (0-12)	College (1-4or			kind of work DO NOT use	retire	ed)		9	07.5		
her ti	ပိ	12			Irans	slator		40.35.4			CIA		
end Mental H Is merked ott aumetic ever	To Be	17. Father's Name (First, Middle, Last) Francesco Fortuna	to							Silve	e, Maiden Sumen Stri	ne)	
ls m	i	19a. fnformant's Name/Relationship (7	ype, Print)								ber, City or Town,		
m 27			xecutor)					y Str	eet,		Arlingt		
Department of Health and Mental Hygiena. Important: If Item 27 Is merked other than "naturany Injury or other traumatic event, the Medical once.		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ 4 □ Donation 5 □ Other (Specify,		cem	etery, crer	osition (Neme metory or other ake Cre	er ple		2	Date 2-10-99	Beltsv	,	wn, State Maryland
Departr Importa any Inju		21. Signature of Funeral Service Licens	7 00	2	Ra		ner	ral Se	rvic	es, P.	A. pring, M	lanyla	and 20910
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications thet cause	d the death.								lai y i c	Approximete
nysician Medical		Immediate Cause (Final disease or condition	ne cause on each	Je4								ř 1	Intervel Between Onset and Death
Examiner		resulting In death)	a	Due to (or a	s a consec	quence of):	-						
#	ne	_	h										
physician and s the burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	0.	Due to (or as	s a consec	quenca of):							
Ding e	Medical	that Initioted events resulting in death) Last	d	Due to (or es	e conseq	uence of):							
d for us	Physician	Pert II. Other significant conditions co	ptributing to death I	but not resultin	a in the u	nderlying cau	so ai	van In Part I		23h Die	I tobacco usa co	ntribute to	the cause of death?
ed by the datached		Corepted Co	_		_		_	hm.	neb.		Yes 2 No		bably 4 Unknow
s been signed	Completed by									24e. Wa	s en autopsy formed?	ava	ere eutopsy findings allable prior to mpletion of ceuse deeth?
ate has b	Eo									1□	Yes 2DNo		Yes 2□No
cartificate	Bec	25. Wes case referred to medical					_	26 Place	of Deat	h (Check only			200
s car direc	TOE	examiner? 1 Pes 2 No	Hospitel:	ient 2□ER	/Outpatier	nt 3 DOA	Ot	her:			sidence 6 Oth	ner (Specifi	y)
h. After this cartific funeral director,	tion: T	27. Manner of Death 1 Naturel 5 Pending 2 Accident Investigation	28a. Date of Inj (Month, De		b. Time of Injury		Inju Wo				how injury occur		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
after death. Director: After	Certification:	3 Suicide 6 Could not be determined	28e. Place of In building, e	njury - At home tc. (Specify)	, farm, str	eet, factory, o	office			28f. Location City or To	(Street end Numi	ber or Rure	I Route Number,
within 24 hours aft To the Funeral Dis completely filled in	edical C	29a. Certifier (Check only one)	afcfan: To the best iner: On the besis of and menner s	of examination	dge, death and/or in	n occurred at vestigation, in	the ti	me, date en opinion, deat	d place, th occurr	aod due to the red at the time	ceuse(s) and ma , date and place,	anner as st end due to	tated. the cause(s)
Somp things	Me	29b. Signature and title of certifier	1.	1	0			se number)		29d. Dete signe		
		30. Name and address of person who c	ompleted ceuse of	death (Item 23	Be) (Type,	Print)	E	PLAC	E F	\$ 502	SEABLE	بالع	UD 20706
Stat	e	31. Date filed (Month, Dey, Year)	32. Regist	rar's Signeture	9 /	1	_	4		- 0,			2010
Registra		FEB 11 199	19 150	wa	Ø.	100	ret	2					



Medical xaminer heral ector		CHARLES								
neral ector			G.	FRE	EDERICK		Month FEB.		Year 999	7:19 AM
neral ector		a. Facility Name (If not institution, giv	e street end number)			4b. City, Town, or Lo		4c. County of		1.17
ector		3-A EASTWAY	RD.			GREENBEL	T	PRINC	E GE	ORGES
ector	5.	Social Security Number 6. S	ax 7. Aç	ge (In yrs. last bii	thday) If Under 1 Yaar Months Deys		8. Date of Birth (Month, Dey,			aca (Stete or Foreign
fled at	- 5	79-40-6005	M 2□ F	87	Yrs.	Hours Mill.	FEB. 2	1912	MA	RYLAND
led a	-	sual Residence of Decedent Oa. State 10b. County		10c. City, Tow	n or Location				10	d. Inside City Limits
	5	MD. PRINCE	CEORCES		GREENBELT					1 ∑ Yes 2 □ No
be notified Director	1	De. Street end Number	GEORGES		10f. Zip Code		1	0g. Citizen of W	hat Count	ry?
ral Di		3-A EASTWAY	RD.		20	770				,
frac must	1	1. Marital Status	12. Was Decedent	Ever in U,S.	13. Was Decedent of H		ecify Yas or No-	14. Race	- Amarica	
eted by Funeral D		1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 1 If Yes, Giva Yeer or Dates:		If Yas, specify Cubi		Rican, etc.)	Specify:	t, White, a	itc.
	3	15. Decedant's Ed	lucation	16a	Decedent's Usual Occup	pation		16b. Kind of Bus		
event, the Medical I	2	(Spacity only highest gre Elementery/Secondary (0-12)	da complatad) College (1-4or:	5+)	(Give kind of work done life. DO NOT use retire	during most of worki d)	ng			
# 6			2	• 1,	N.S.A.			U.S.	GOV	¹T.
Be (1	7. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, M	Meiden Surneme)	
Imatic event, the Manager To Be Comp		KARLL G	. FRE	DERICK			ANNA	NICKO	LTZ	
or other traumatic	1	9a. Informant's Name/Relationship (196	. Mailing Address (Street	end Number or Rura	al Route Number	, City or Town, S	Stete, Zip (Code)
her			RICK/WIFE	OOb Diese O	SAME AS Disposition (Name of	ITEM #10				
9 0	2	Da. Method of Disposition 1 Description 3 D	Ramoval from State	cemete	ry, cremetory or other pla	ce)	Date	20c. Location - (City or Tow	n, State
lary		4 □ Donation 5 □ Other (Specify		CHAM	BERS CREMAT		/9/99	RIVER	DALE	, MD.
any injury or other trac	2	Signefure of Funeral Service Ligar	600	2	22. Name and Addre	ess of Facility				
		3a. Part1. Enter tha disease, or com shock, or heert feilure. List only	neeuse	- MOOO91	CHAMBERS F	UNERAL HO	MES, P.A.	RIVER	DALE	, MD. 2073
Examiner		equentially list conditions,	b	Due to (or es a	MER'S consequence of):	DISER				9
as the burial-transit	GC ff	equentially list conditions, any, leading to immediate ause. Enter Underlying euse (Disease or Injury let initieted events seutting In death) Lest	C	Due to (or as a	consequence of):					
Physician/N	P	art II. Other eignificent conditions or	d.	ut not resulting it	a the underlying cause of	ron in Doct i	22h Did to		belloute to	the cause of death
hys						ren in Perci.				ably 4 🗍 Unknow
be da	-	CARCINO	11 A	BCA	DDER					
should	_						24a. Was a perform	n autopsy ned?	evai	re eutopsy findings ilable prior fo apletion of cause eath?
omp							1 □ Ye	s 2000	10	Yes 2 No
Be Co		5. Wes cese referred to medical				26. Place of Death	(Check only on	e)		
To F		examiner? 1 Yes 2 100	Hospital: 1 Inpatie	ent ZILVERVOL	tpetient 3 DOA Oth	ner: 4 Nursing Ho	me 5 Reside	enca 6 □Othe	r (Specify))
e funeral		7. Manner of Death 1. Deatural 5 Pending 2 Accident investigation	28e. Date of inju (Month, Da		Fime of njury 28c. Injur Wor 1 □	y at rk? Yes 2 □ No	28d. Describe ho	ow Injury occurre	əd	
completely filled in by the funeral director, pege Medical Certification: To Be Com	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location						28f. Location (St City or Town		r or Rurel	Route Number,
edical C		9a. Certifier (Check only one) 1 Certifying Physics 2 Medicat Example 1	/elcien: To the best iner: On the basis of end manner st	exemination an	, death occurred et the tir d/or Investigation, in my o	me, dete end place, opinion, death occurre	and due to the ca	ause(s) end men ate and place, a	ner es sta nd due to t	ited. the ceusa(s)
Me		9b. Signetura and title of certifier			29c. Licans	a number	2	9d. Date signed	(Month, D	ley, Year)
Ĭ		Rsurile	M. M)	DO	0509	51	218	190	7
	30	D. Neme end address of person who of REVA · S · GIE		leath (Item 23e)						M.N. 200
l l	-	I. Date filed (Month, Day, Year)		ar's Signature	G. Spore					, , , , , , , ,

Registrar

DHMH 16 Rev 6/95

and the state of t TO COUNTY INC. A DECEMBER OF THE PERSON OF TH . 1 Name and April 1985. Reg 1850 on The Artist American Laboratory Tree. If you a low . . . Martin a committee them to be a few to fine the committee that a few terms are the committee that the

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

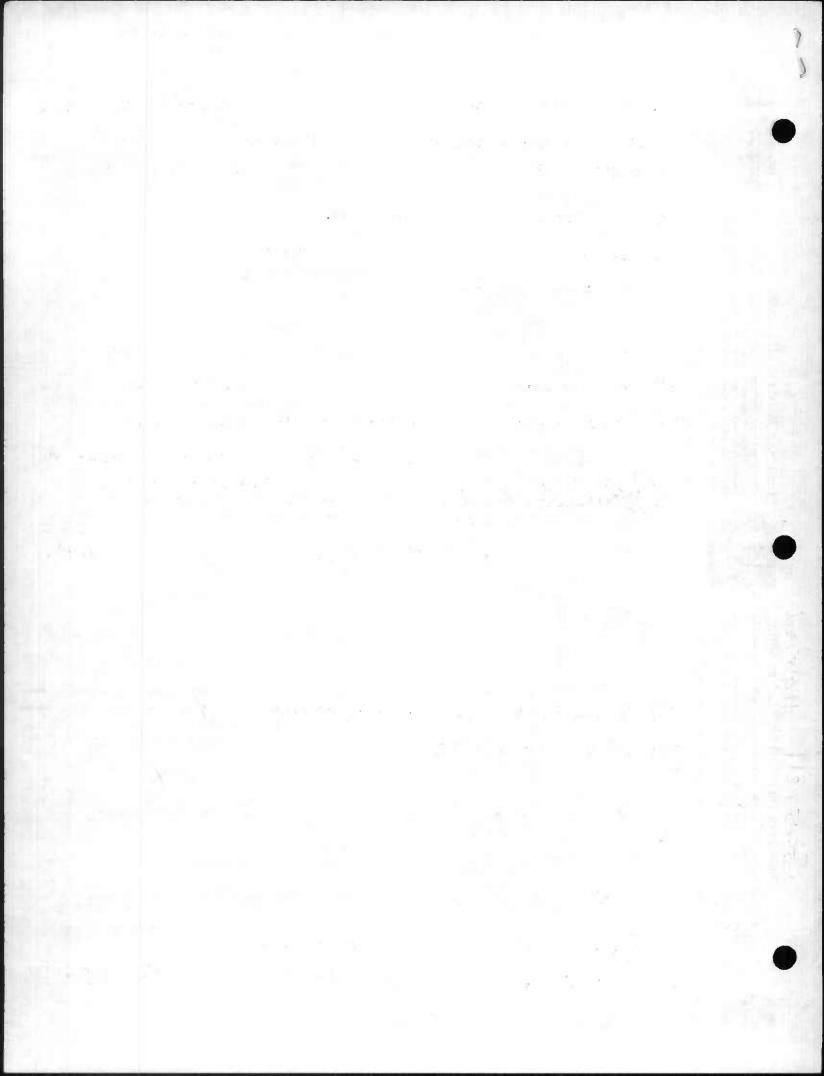
	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT OF	HEALTH AND N	MENTAL HYGIEN	E	
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATN	la una	3. TIME OF DEATN
	Mary JoAnn Grant					February 5	, 1999	0200 M
	4. SOCIAL SECURITY NUMBER		In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	Co	RTNPLACE (State or Foreign puntry)
- 8	213-42-0704 9e. FACILITY NAME (If not institution, give str		4 YRS.	OF OLEN ASME	OR LOCATION OF DE		944 Ma	
NG.	Kent & Queen Anne				ertown	ATH	se county of Kent	PF DEATN
5	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY		10.00				rene	
DIRECTOR	Maryland Caro			y, town on Loc .dsboro	ATION			10d. INSIDE CITY LIMITS? 1. YES 2 NO
AL	10e. STREET AND NUMBER				of, ZIP CODE		10g. CITIZEN (OF WHAT COUNTRY?
FUNERAL	425 Main Street				21636	_	USA	
5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES			CENDENT OF NISPANI	C ORIGIN? (Specify Yea		ACE — American Indian, lieck, White, etc.
B√	3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DA		1 🗆 YE	S 2 NO Specify:			pocmy White
0	15. DECEDENT'S EDUC (Specify only highest grade of	ATION	18a. DECEDENT'S	USUAL OCCUPAT	ION	16b. KIND OF BUS	I SINESS/INDUSTR	Υ
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u	se retired.)	lost or working			
₽	12 17. FATNER'S NAME (First, Middle, Last)	4	Counsel	or		Domestic V		
	Joseph Andrew Fabe	er Sr				NE (First, Middle, Maiden : Virginia U	,	
BE	19a. INFORMANT'S NAME (Type/Print)	L, DL.	196. MAILING	ADDRESS (Street		Oute Number, City or Town)
임	Tonya Lynn Carpent	ter/Daughter	425 Ma	in Stre	et, Golds	boro, MD	21636	
	20a. METHOD OF DISPOSITION 1 ☐ Burlal 2 ⚠ Cremation 3 ☐ Remo	rval from State / com	PLACE AND DATE	OF DISPOSITION (/	lame of	DATE 20c. LOC	CATION — City o	
- 1	4 Donation 5 Other (Specify)	2 C	hurch Hi	11 Ceme	tery	2/9/99 Chu	rch Hi	ll, Maryland
	· Ohrs 4	//	4	Fellow	s, Helfenbe	in & Newnam :	Funeral I	Home, P.A.
	23. PART I. Enter the diseases or or	omplications that color	the death Do	130 St	eer Road, C	hestertown.	MD 21620	
	23. PART I. Enter the diseases, or contained the shock, or heart fallura. LimmeDiate Cause (Final	iat only one cause on a	ech lina.	iot anter tha in	oua or dying, auch	an carolac or respi	ratory arrest,	Approximata interval Between Onset and Daath
	disease or condition resulting in death)	VSEPTIC S	HOCK					3/5
	rounting in datati)	DUE TO (OR AS A	CONSEQUENCE O		-			Onrs.
NO	Sequentially list conditions,	PNEUMON	CONSEQUENCE O		EMOLYT	IC STRE	P	5 days
CAT	If any, lasding to immediats cause. Enter UNDERLYING		0011320021102					
Ĕ	CAUSE (Disesse or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE O	F):				
CERTIFICATION	resulting in death) LAST	•						
AL 0	PART ii. Other significant conditions	contributing to death b	ut not reaulting	in the underlyi	ng cause given in F	Pert i. 24a, WAS AN A		24b. WERE AUTOPSY FINDINGS
200	CHRONIC OBST	RUCTIVE P	numon.	ORY D	ISEASE	1 TYES 2	meo.	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN?
¥						_		1 TYES 2 NO
PHYSICIAN: MEDIC	DID TOBACCO USE CONTR		F DEATH YE					
SICI	EXAMINER?	HOSPITAL:		OTHER:	ne 5 🗆 Realdence s			
훉┃	27. MANNER OF DEATN	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c, IN	JURY AT ORK?	28d. DESCRIBE NOW IN	JURY OCCURED	
B\	1 Natural 5 Pending 2 Accident Investigation			M 1 [YES 2 NO			
	3 Suicide 8 Could not be determined	26e, PLACE OF INJURY building, atc. (Spec	— At home, farm, :	street, factory, offi	ce	281. LOCATION (Street a: City or Town, State)	nd Number or Ru	ral Route Number,
E	29a. CERTIFIER		5254240535545		W/ 27 DE SESSE			
COMPLETED		EIAN: To the best of my knowl R: On the basis of examination						se(a) and manner on stated
	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUM			ISD (Month.; Day, Year)
BE	Du ANOT	en mo			4	87	▶ 7	15 199
임	30. NAME AND ADDRESS OF PERSON WHO			,				
7	Helen A. Noble, 122 S			ertown, M	laryland 216	20		
'	FEB 0.8 1999	32. REGISTRAR'S SIGNA		1				
1	1 LD U 0 1333		1.	Spark				DUMAN OF Day 1890

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended Item #29d, per Phy. State of Maryland / Department of Health and Mental Hygiene Q 2/8/99, Carroll County, wjl Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death February I **Physician** Howard Hanson Gosnell, Sr. 9:20 /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Carroll Carroll County General Hospital Westminster If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Mar. 3, 19 Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) **Funeral** 1 XM 2 ☐ F Months Deys Hours Min 87 Yrs. Maryland 212-32-0015 Director Usuel Residence of Decedent the Marylend 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 Ves 2 □ No Westminster Carroll Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? r than "natural", or items 23a or the Medical Examiner must be a 21157 U.S.A. 810 David Ave. permit. Peges 1 end 2 should be filed within 72 hours after deeth v Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must page. Funeral 14. Rece - American Indian, Bleck, White, etc. 11. Meritel Status 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Married 2 N Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 K No Specify: White g 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10 farmer dairy 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Olga Jane Conaway William Edward Gosnell 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Westminster, MD 21157 Emma M. Gosnell/ wife 810 David Ave. 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 2/4/99 nr. New Windsor, MD Sams Creek Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility Hartzler Funeral Home of Funeral Service Licenses 10 310 Church St. New Windsor, MD 21776 23a. Pert1. Enter the disease, or complications that cause and deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervei Between Onset and Deeth **Physician** Immediete Cause (Final disease or condition resulting in death) EMPHYSEMA /Medical DYUS. Examiner Examiner physician end the burial-transit Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Howard P.O. Box 68760. Physician/Medical Due to (or es e consequence of): as for use as Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the a Yes 2 No 3 Probably 4 Unknown ISCHEMIC CARDIOMY OPATH Division of Vital Records, by 24b. Were eutopsy findings evelleble prior to completion of cause of death? PAN SINUSITIS 24e. Wes en eutopsy performed? Completed Josnal 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes cese referred to medicel exeminer? Be 26. Piece of Deeth (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpetient P 3 DOA funeral 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 1 Naturei 2 Accident 5 Pending after death. Director: Aft 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide McCertifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner steted. 29a. Certifier Medicai (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) apollera 129264 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)
Nr PATPACA. 217 - Washington Hts. Washinster M 21157 31. Dete filed (Month, Dey, Year) 32. Regiştrer's Signature State

Registrar

FEB 0 8 1999

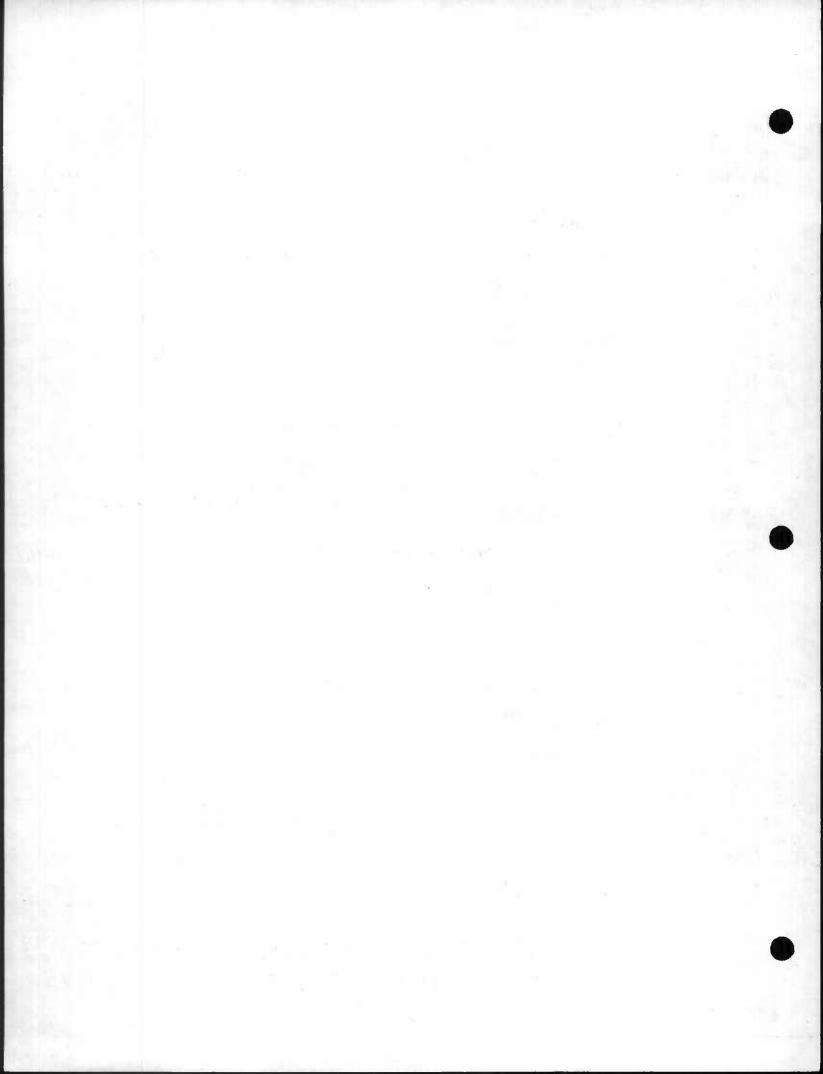


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Remo E. Ray Ghion February 3, 1999 8:15 PM /Medical 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Silver Spring 13404 Bingham Court Montgomery If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F Director 209-32-0231 58 August 23,1940 Pennsylvania Usual Residence of Deceden 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 ☐ Yes 2 K No Directo 258-1 Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code ò Barrie 23a 13404 Bingham Court 20906 Funeral U.S.A. 14. Race - American Indian, 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status Black, White, etc. 1⊠Yes 2□No If Yes, Give Year or Detes: 1969 1 ☐ Never Merried 2K Merried 8 Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Federal Systems Div. permit. Pages 1 and 2 should be flied with Department of Health and Mental Hygien important: If Item 27 is marked other the any Injury or other treumelic award. 5+ Vice President Bell Atlantic 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be Raymond Ghion Dorothy Spaniel 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Mary Ann Ghion 13404 Bingham Court (wife) Silver Spring, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20c. Location - City or Town, State Dete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Gate of Heaven Cemetery 02/6/99 Silver Spring, Maryland 22. Name end Address of Facility 21. Signature of Euneral Service Licensee Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Malignant Glioma

Due to (or as a consequence of): Examiner Examiner Disorder physician and the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760 Physician/Medicai Due to (or es e consequence of): 980 Pert it. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hyperlipidemia Division of Vital Records, þ 24b. Were eutopsy findings evailable prior to 24a. Wes an autopsy performed? Completed completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 No Be 25. Wes case referred to medical examiner? 26. Piace of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No 10 this 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of Injury 28d. Describe how injury occurred edical Certification: 28c. Injury et Work? or Attending 5 Pending investigation . To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fune 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Craifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and manner as stated. 29e. Certifier (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signeture end title of certifier 29c. License number Godend D45956 awn + 0 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Dawn Broderick 18111 Prince Phillip Dr. T12, Dlney, MD 20832 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State FEB 0 8 1999 Registrar



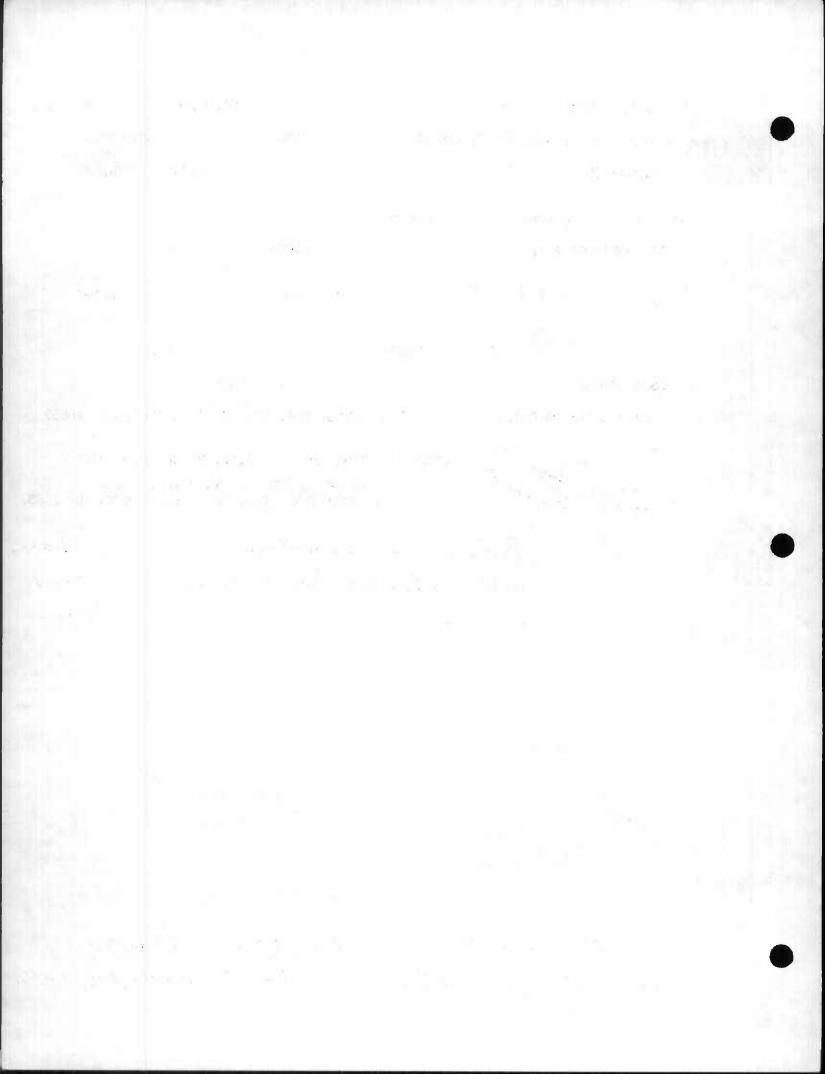
State of Maryland / Department of Health and Mental Hygiene O Certificate of Death Reg. No. 1. Decedant's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day Month **Physician** 02.10.1999 6:00 PM REGINA LANGSAM GOLDBERG /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner MONTGOMERY HEBREW HOME OF GREATER WASHINGTON ROCKVILLE If Undar 24 Hrs. If Under 1 Year 8. Deta of Birth (Month, Dey, Year) Birthpleca (Stete or Foreign
Country) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Deys 1 M 2 F Months Hours 91 12.21.1907 GERMANY Director 062.30.1125 Usual Residance of Decedent with the Mendend 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f ahovevent, the Medical Examiner must be noticed at 1 Yas 2 No Director MARYLAND MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20852 6105 MONTROSE ROAD USA Funeral death 12. Wes Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Maritel Status 14. Reca - Amarican Indian. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or iten any injury or other traumatic event, the Medical Examine. Black, Whita, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 If Yes, Give Yeer or Detes: 1 Yes 2 No Specify: Specify: WHITE by 3 □Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) SALES RETAIL 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) MOSES LANGSAM EDITH TREFF 19a. informant's Name/Reletionship (Typa, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) MALKA FINKEL/ DAUGHTER 5901 MONTROSE ROAD #N1202, ROCKVILLE, MD 20852 20b. Piece of Disposition (Neme of cametery, cremetory or other piece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Buriel 2 Crametion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) JUDEAN MEMORIAL GDNS 2.12.99 OLNEY, MARYLAND 21. Signeture of Funerel Servica 22. Name end Address of Fecilit EDWARD SAGEL FUNERAL DIRECTION, 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23e. Pent. Enter the disaese, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heer failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner ettending physician and for use es the buriel-trensit certificate be executed Sequantially list conditions, if any, leading to immadiate cause. Enter Underlying Ceuse (Disease or injury that Initiated events rasulting in death) Last Due to (or es e consequence of) Box 68760 The law requires that the death 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. the signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were eutopsy findings availebla prior to completion of cause of death? been si 24e. Wes en eutopsy performed? Completed hes e 2 1 Yes 1 ☐ Yes 2 ☐ No certificate Physician: 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: Othar: 4 Nursing Home 5 ☐ Residence 6 ☐ Othar (Specify) Lo 20 No 1 Yes 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28e. Dete of Injury (Month, Dey Year) 27. Menney of Deeth 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of Certification: After t or Attending 5 Pending investigation 1 Naturel 1 Yes 2 No deeth. Director: / 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street end Number or Rural Routa Numbar, City or Town, Stete) 28a. Placa of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) efter 4 ☐ Homicide To the Hospital o within 24 hours of To the Funeral Di 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner stated. edical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. Licansa number 29b. Signeture and title of cartifier 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Rd., Rolleville, MD Feldman 6105 Montros MD

32 R

strer's Signeture

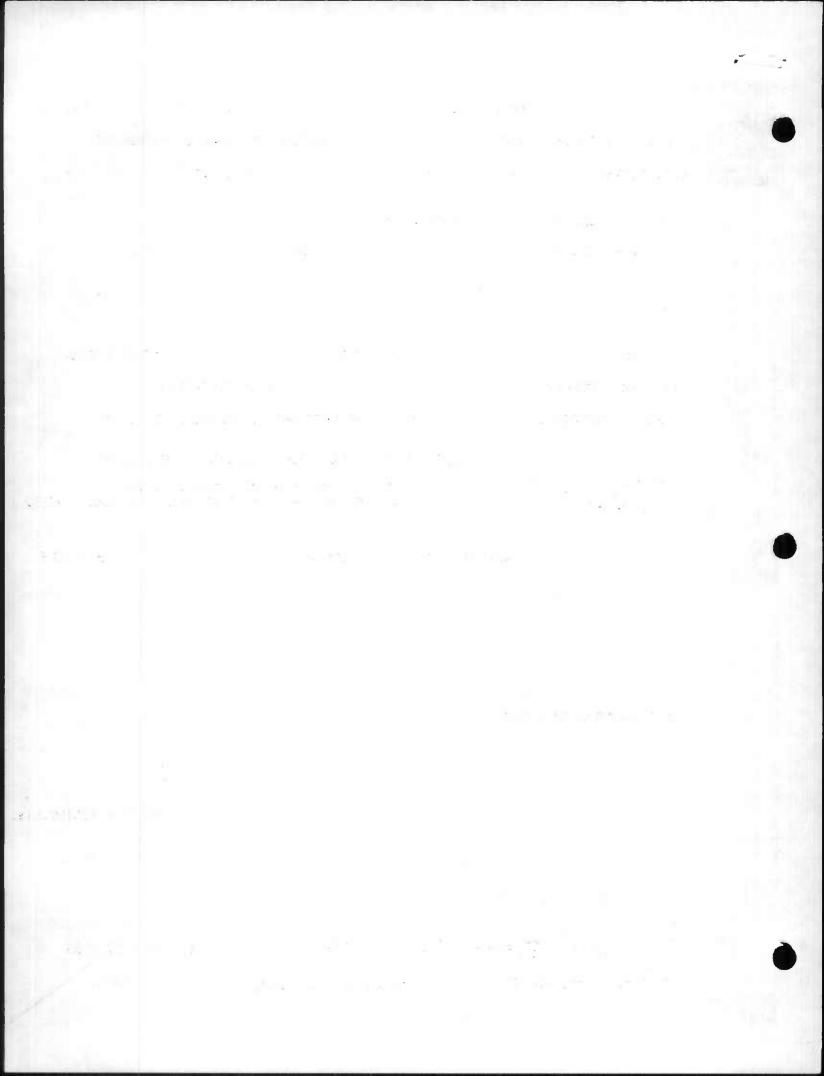
State Registra



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ESSTE 02.01.1999 2:10 PM COLDSTEIN /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SUNRISE ASSISTED LIVING MONTGOMERY VILLAGE MONTGOMERY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2□F Months Days Hours 88 Yrs. Director NY 058.03.3211 08.14.1910 Usual Residence of Decedent the Marylend 10a State 10h County 10c. City. Town or Location 10d. fnslde Clty Llmits 28a-f ahow 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at Y☐ Yes 2☐ No Director MARYLAND MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6111 MONTROSE ROAD 20852 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours effer c Depertment of Health and Mentel Hygiene. Important: If item 27 Is marked other than "natural", or iten any Injury or other traumatic event, the Medical Example. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE py 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 BOOKKEEPER MANUFACTURER 18 Mother's Name (First Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be ISADORE KREVITSKY ANNA EISENSTADT 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 202 FOREST LAKE DRIVE, MADISON, MS MARK GOLDSTEIN/SON 20b. Place of Disposition (Name of cometery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 元 Removal from State LAKESIDE MEMORIAL PARK 2.6.99 MIAMI, FLORIDA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 chief the diselve, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) ADENOCARCINOMA OF THE STOMACH 3 MONTHS Examiner Due to (or as a consequence of) Examiner iclan end buriel-transit certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Box 68760 physiclan Physician/Medical the Due to (or as a consequence of): attending ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by d 1 Yee 3 No 3 Probably 4 Unknown EHLERS-DANLOS SYNDROME Division of Vital Records. p 24b. Were autopsy findings available prior to 24a. Was an autopsy Completed peen completion of cause of death? 198 2 No 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSIST.LIV P 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: 28b. Time of 28c. fnjury at Work? 1 Natural 5 Pending 1 Tyes 2 No death. investigation 2 Accident or Attended of the offer death 6 Could not be determined 3 Suicide Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) ompletely filled in by 4 Homicide Hospital 24 hours e 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2 To the 29c. License number 29d, Date signed (Month, Dev. Yeer) 29b. Signatory and title of certifier D07285 FEBRUARY 9, 1998 and eddress of person who completed cause of death (Item 23a) (Type, Print) JAMES A. BROWN, MD 9707 MEDICAL CENTER DRIVE, ROCKVILLE, MARYLAND 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 10 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

Physician /Medical Examiner	4
	1

Funeral Director

filed within 72 hours efter deeth with the Marylend than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at Hygiene. 7 le marked other treumstic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 Ie marked othe any Injury or other treumatic event,

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

ettending physician and for use es the buriel-transit the death certificate be executed ed by the e signed t Division of Vital Records, certificate hes b lirector, page 2 s spital or Attending Physician: Thours after death.

neral Director: After this certification in the funeral director, pa Hospital 24 hours

Box 68760.

P.O.

1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Tima of Death Month Rudo1ph Edward Gomez February 3, 1999 6:20 a.m. 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death 5619 Wood Way Bethesda Montgomery If Under 1 Yaar | If Undar 24 Hrs. 5. Social Sacurity Number 7. Aga (In vrs. last birthday) 8. Data of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Days Months 10 M 20 F Hours 577-60-5654 83 May 27, 1915 Arizona Usuel Rasidence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits MD Montgomery Bethesda 1 X Yes 2 □ No Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5619 Wood Way 20816 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, 11. Meritel Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Black, White, etc. 1 X es 2 No If Yes, Give Year or Detes: 1 Navar Married 2 Married 1 Nes 2 No Specify: Spaniard Specify: White þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Central Intelligence Elementery/Secondary (0-12) College (1-4or 5+) 4+ Chief Of Station Agency 18. Mother's Name (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) Be Arnulfo R. Gomez Encarnacion Bueras 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Wife Elizabeth Eacret Bowlby Gomez 5619 Wood Way, Bethesda, MD 20816 20b. Ptece of Disposition (Neme of cemetery, cremetery or other p 20e. Method of Disposition 20c. Location - City or Town, Stete Baltimore/Washington Crematory 1 ☐ Buriel 2 TxCremetion 3 ☐ Removet from State 2-7-99 Laurel, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Joseph Gawler's Sons, Inc. 21. Signature of Funeral Service License 5130 Wisconsin Avenue, N.W., Washington D.C. or complications thet caused tha death. Do not enter the mode of dying, such es cardiac or respiratory errest, st only one cause on each line. Approximete Interval Between Onset and Death Immediete Ceuse (Finat Non-Small Cell Lung Cancer 7 months disaese or condition resulting in death) Due to (or as e consequence of) Examiner Sequantially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that intileted events resulting in deeth) Lest Due to (or as a consequence of): Physician/Medical Due to (or as e consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Prostate Cancer by 24e. Wes an autopsy performed? 24b. Were eutopsy findings aveilable prior to Completed completion of cause of deeth? 1 ☐ Yes 2 No 1 Yas 2 No 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 ☐ Nursing Home 5 🖔 Residence 6 ☐ Other (Specify) P Dete of Injury (Month, Dey Year) 28b. Time of injury 28d. Describe how injury occurred 27. Mennar of Deeth Certification: 28c. Injury et Work? 1 Neturel 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 3 Sulcida 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1X Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) and menner es steled.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and menner steled. 29e. Certifier To the Hosp within 24 hor To the Fune completely fi edical

State Registrar

Ross Donehower, M.D. 31. Data filed (Month, Dey, Year) FEB 08

(Check only 29b. Signature a

32. Registrer's Signature

MOULDONNER MEDICAL ONCOLOGY

30. Name end eddress of person who completed cause of deeth (ttem 23e) (Type, Print)

DIRECTOR,

600 North Wolfe Street, Baltimore, MD 21287 ooks

29c. Licansa number

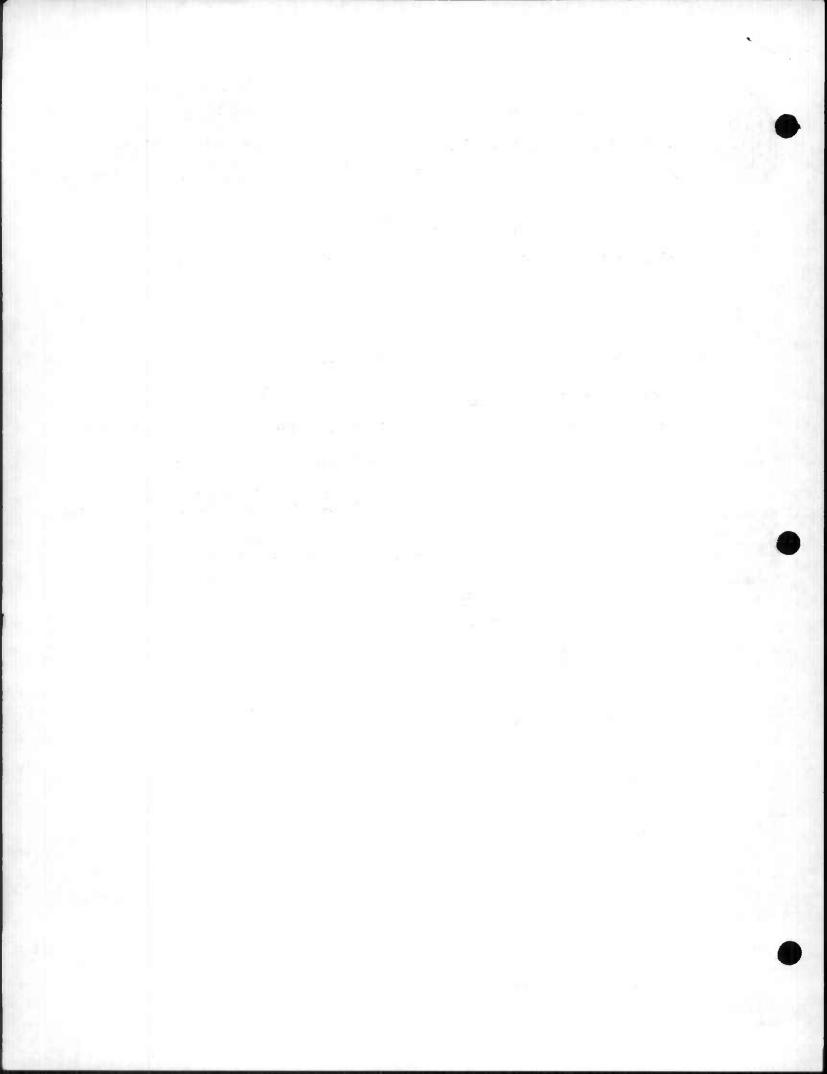
29d. Dete signed (Month, Dey, Year)

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should be marked o	Grant Johnson				Bessie	(Gordon)	
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80558	X2 n. 16	100		R.N. Hor	ton Co. Mort	icians, Inc	
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Sparks

State

Registrar



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21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Robert A. Pumphrey Funeral Home/Rockville, Inc.													
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15225 Shady Grove Road #302 Rockville, Maryland 20850-3234

State Registrar

Philip J. Schwartz, M.D. 15225 Sh.

31. Dete filed (Month, Day, Year)
FEB 11 1999

32. Registrer's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

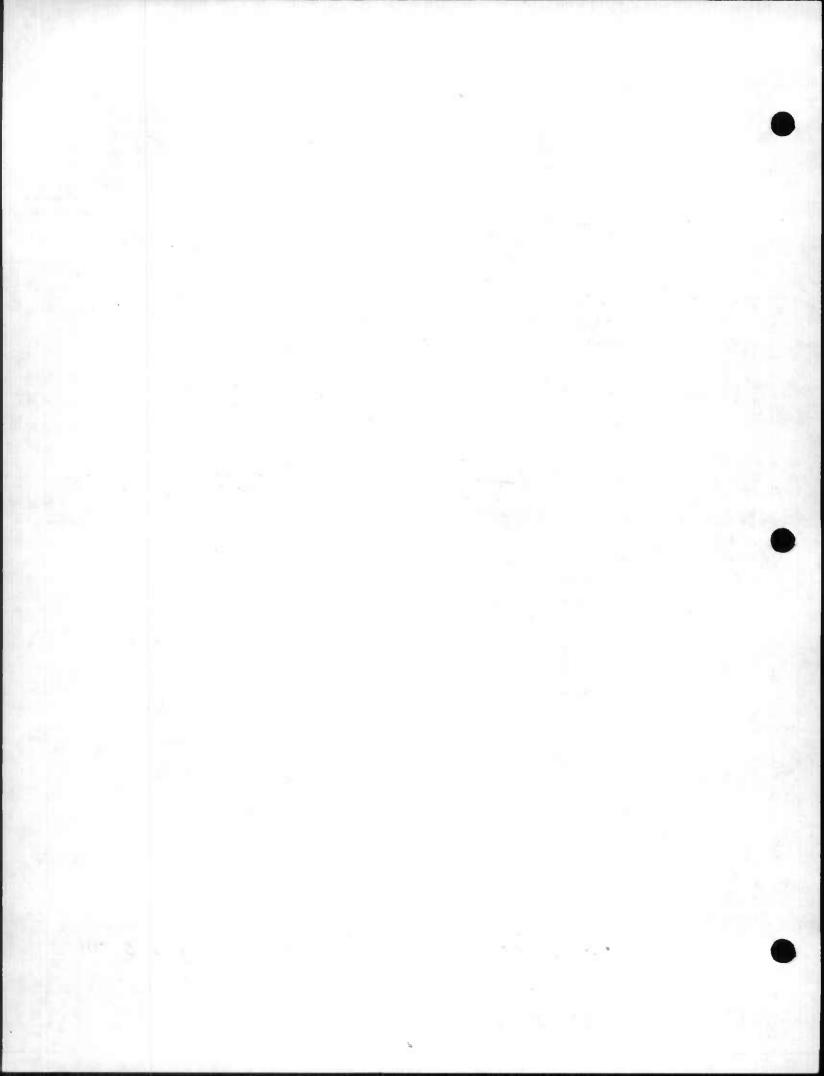
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State of Maryland / Department of Health and Mental Hygiene 9 051.08

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aiam.	1. Decedent's Nama (First, Middla,	Last)						:	2. Data of De Month	eath Day	Yea		of Death
cian dical	FRANK PAUL GUGLI	OTTA						F	EBRUA		1999		1 P.M
niner	4a Facility Nama (If not institution,	giva street and number	7)			4	b. City, Tow	m, or Loc	ation of Deat	h 4c. Co	unty of De	ath	
	HOLY CROSS HOSPI						ILVER				TGOMI		
		6. Sex 7. A	ga (In yrs. last		If Under 1 Months	1 Year Days	If Under 2 Hours	Min.	B. Data of Bir (Month, De	nth ay, Year)	9. B	lirthplace (Star Country)	e or Foreig
	227-38-5259	7421 M 2 G 1	7	7 Yrs.				J	TUL. 1	8, 192	1 ITA	ALY	
	Usual Rasidanca of Decedent 10a. Stata 10b. County		10c. City, T	own or Loca	ation							10d. Inside	City Limit
5		CRODORG											es 2XXV
Director	MARYLAND PRINCE 10e. Street and Number	GEORGES	ADELP	HI	10f. Zip (Cada				10g. Citizen	-4 M/h-4 /	Courted	
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Funeral	11. Marital Status	12. Was Deceder Armed Forcas	?	13. W	as Decede Yas, speci	ent of Hi	ispanic Origin, Mexican,	in? (Spec Puerto R	ify Yas or No ican, atc.)	p- 14.	Race - Ar Black, WI	nerican Indian hita, atc.	
by	1 ☐ Naver Married ※ Marrie 3 ☐ Widowed 4 ☐ Divorced	if Yas ∭ if Yas, Giva Yaar or Datas			□ Yas 🕺		Specify:				ecity:	HITE	
Completed	15. Decedent's (Specify only highast		1	6a. Decede	ind of work	k done d	durina most	of working	9	16b. Kind	of Busines	ss/Industry	
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Be	17. Fathar's Nama (First, Middla, Li	ast)					18. Mother	s Name	(FIRST, MIDDIE	, Maiden Sui	mama)		
2	JOSEPH GUGLIOTTA								PAGLIA				
1915	19a. Informant's Name/Ralationshi									er, City or To			
	FLORENCE GUGLIOT	TA (WIFE)					LL ROA	AD AD		MARYL			
	20a. Method of Disposition 1 XX urial 2 ☐ Cramation 3	3 □Removal from Stat	COTT	a of Disposi atary, crama			e)	FF	Data EB.05,	20c. Locat	ion - City	or Town, Stata	
	4 □ Donation 5 □ Other (Spe		GATE				MTERY	1	999			ING MAR	
	21. Signatura of Funaral Sarvice U	ahmat		22.	Nema and	d Addras	ss of Facility	1180	O NEW	HAMPS	HIRE	AL HOME AVENUE	
	OZO Plati Etler the disease or a	emplications the dur	ad the death. [Do not onto	the made	ad shalm	a cueb es e				ARYL	AND 209	
	23a. Vart1. Entar tha disease, or c	nly ona causa on each	lina.	o not antai	tha moda	1 Of Gylft	g, such as c	ardiac or	respiratory a	illest,		Interval I	Between
n Il	Immediate Causa (Final												
	disaese or condition rasulting in daath)	a RENAL FA	AILURE									YEARS	
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ulu		b. CEREBRO	VASCULA	R ACC	IDENT	7						MONTH	
Examiner	Sequentially list conditions,		Dua to (or as	a consequ	ence of):								
<u>e</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	c.ANEMIA										YEARS	
edical	that initiated evants rasulting in death) Last	3	Due to (or as	a conseque	ance of):								
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hys	tarii. Other aiginiount sondition	• contributing to doubt	but not resultin	g iii tila tili	Jonying ou	iusa givi	on are are a			Yes 2/01		Probably 4	
y P								_		72	40 0	, rocably	
20										an autopsy	24	b. Were autop	sy tindings
(pert	ormed?		completion of death?	
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omple							00 51	10			***	1 1 1 1 1 2	
Completed by Physician/	OF Man and returned to medical					Othe	or.		(Check only		10.1		
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To Be	axaminar? 1 Yas 2 No 27. Mennar of Death 1 Notural 5 Pending	28a. Date of In (Month, D	ury 28	Outpatient b. Time of Injury	28	Bc. Injun Worl	y et k?	20		how injury o	ccurred		
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75		State of Maryland / Department of Health Certificate of Death		ygiene Reg. No. 99	051.09
Physic /Med		1. Decedent's Name (First, Middle, Last) CATHERINE READ HALL	2. Dete of Det	Ary B 19	aar 4570m
Exam Funera Directo	1		Min. (Month, I	KEN 7 Birth Dey, Year)	
faryland of the own	or	Usuel Residence of Decedant 10a. Stata 10b. County 10c. City, Town or Location MD QUEEN ANNES CENTREVILLE			10d. Inside City Limits 1 ★ Yes 2 □ No
fer death with the Marylan Rems 23s or 28s-f show	ai Director	10e. Street and Number 10f. Zip Coda 205 ARMSTRONG AVE. 21617		10g. Citizen of Who	•
5-UUZU 72 hours after death with the Maryland natural, or items 23s or 28s-f show dical Examiner must be notified at	by Funeral	11. Marital Status 12. Was Decedent Ever In U,S. Armed Forces? 1 □ Never Merried 2 □ Merried if Yes, specify Cuben, Mexical if Yes, Size 1 □ Yes 2 ▼ No If Yes, Gize 1 □ Yes 2 ▼ No Specify:	n, Puarto Rican, atc.)	No- 14. Race - Bleck, Specify:	American Indien, White, etc.
S 1/8	Completed b	15. Decedent's Education (Specify only highast grada completed) Elementery/Secondery (0-12) College (1-4or 5+) 16e. Decedant's Usual Occupetion (Give kind of work done during mos		16b. Kind of Busin	ness/Industry
	e e	17. Fether's Neme (First, Middle, Last) RETAIL BOOK SA 18. Mother	er's Neme (First, Midd	lle, Meiden Sumeme)	48 BOOKS
Mar 12 shc h and 7 le m traum	To	EDGAR THOMAS KEAD 19a. Informent's Neme/Relationship (Type, Print) TOAN HALL WISE P.O. Box 304 CH		nber, City or Town, St	ete, Zip Code)
8 5 4		20e. Method of Disposition 1 Burial 2 Cremetion 3 Removal from Stata 4 Donetion 5 Othar (Spacity) 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) CHESAPENKE CREMATO	Dete	20c. Location - Ci	ty or Town, Stata
Dailling permit. Page Department: importent: if any injury or		21. Signatura of Funeral Servica Licensee 22. Neme and Address of Facility MARYIN V. WILL FUNERAL SERVICE	LIAMS P.	U. BOX 223	V,MD 21620
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as shock or heart feilure. List only one ceuse on each line. Immediate Ceuse (Fine) disease or condition resulting in death) e. Ture mycommunity in the mode of dying, such as shock or heart feilure. List only one ceuse on each line.			Approximate Intarval Between Onset and Death
icata be executed physician and s the burial-transit	dical Examiner	Sequentieity list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last b. Due to (or as e consequence of): c. Dua to (or es e consequence of):			
ox over incoming use as		d			
d by the	y Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part		41	ibute to the cause of death? Probably 4 Unknown
he law requires to a has been signe	Completed by			as an autopsy rformed?	24b. Were eutopsy findings aveilable prior to completion of cause of death?
= F # 6	Be Con	25. Wes cese referred to medical 26. Place	1 E of Deeth (Check on)	Yes 2 No	1 Yas 2 No
al di di	2	examiner? 1		sidence 6 Other e how injury occurred	
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Certification:	3 Sulcide 6 Could not be determined 28e. Pleca of Injury - At home, ferm, streat, fectory, office building, etc. (Specify)	City or 1	Town, Stete)	or Rural Routa Number,
To the Hospital or A within 24 hours affer To the Funeral Dire completaly filled in b	edical	29a. Certifier (Check only one) 1 Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, dete er constant of the basis of exeminetion end/or investigation, in my opinion, deed and mannar stated.	nd piace, end due to the eth occurred at the time	ne cause(s) end mann e, dete and place, an	er as stated. d due to the ceuse(s)
To th To th comp	Me	29b. Signature and title of certifiar 29c. Licansa number 0-13 + 2	4	29d. Dete signed (
St	ate	30. Name end intress of person who completed ceuse of deeth (Item 23a) (Type, Print) To HN (SEYMO IL CHESTERTOWN, MD 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture FFB 1 0 1999	2/620		
Regist		FFB 1 0 1999 Deneva & Soule			

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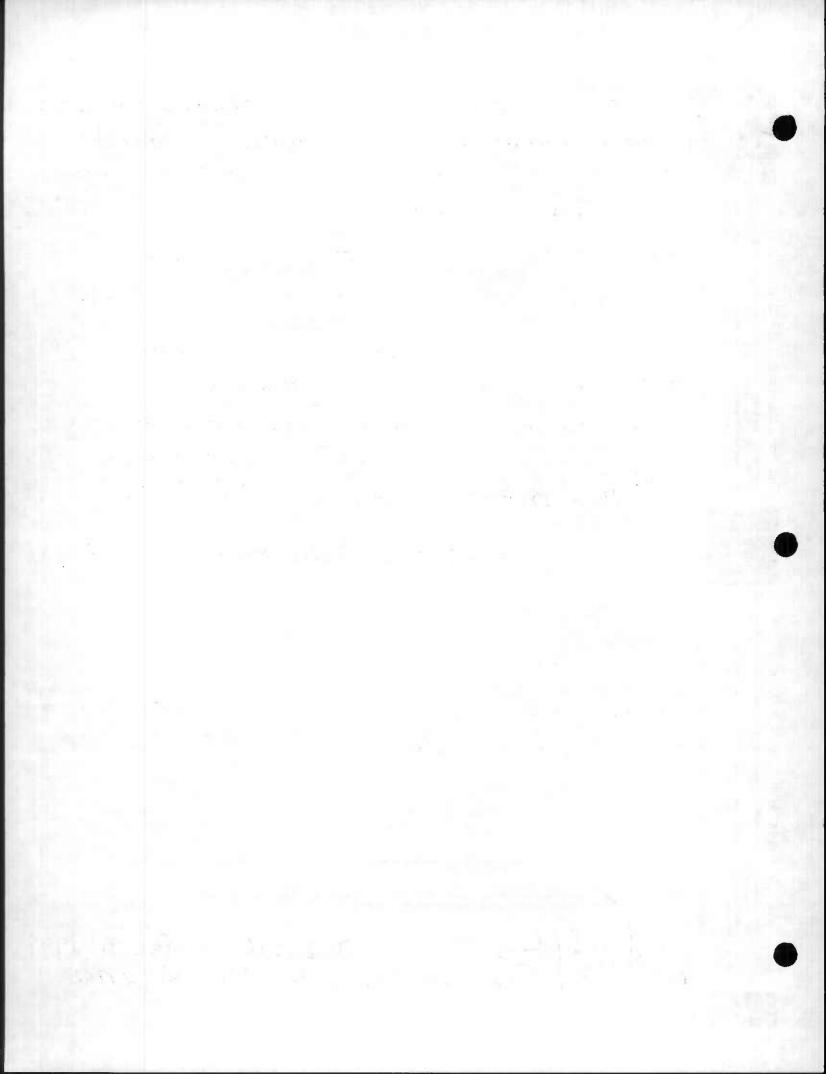
State of Maryland / Department of Health and Mental Hygiene 9 951

	Cei	rtificate of Death	Reg. No.	
hysician	1. Decedant's Nama (First, Middla, Last)		2. Dete of Daeth Month Day	3. Tima of Deeth
nedical	HELEN HINMAN		FEBRUARY 2	
miner	4e Fecility Neme (If not Institution, give street end number)	4b. City, Town, or Loc	cation of Death 4c.	County of Death
	Frederick Memorial Hospital	Frederick		Frederick
ector	5. Social Security Number 20-34-5417 6. Sax 1 M 2 F 7. Aga (In yrs. last birthday) Vsual Residence of Decedant	if Undar 1 Year If Undar 24 Hrs. Months Days Hours Min.	8. Data of Birth (Month, Day, Year) Jan. 8, 19	9. Birthplaca (Stata or Foreign Country) 15 Maryland
1	10e. Stata 10b. County 10c. City, Town or Lo	ocation		10d. Insida City Limits
iner must be notified at Funeral Director	MD Carroll New Wind	sor		1 ☐ Yas 2 🖾 No
Olre	10e. Street and Number	10f. Zip Coda	10g. Citi	zan of What Country?
1 10	3520 Hawks Hill Rd.	21776	U.S	.A.
Tue Tue	11. Maritei Status 12. Wes Dacedent Ever in U,S. Armed Forcas?	Was Decedant of Hispanic Origin? (Spe If Yas, specify Cuben, Mexican, Puarto F	cify Yes or No- Rican, atc.)	14. Rece - American Indien, Black, Whita, atc.
by	1 Naver Married 2 Merried 1 Yes 2 X No	1 □ Yas 2 ☒ No Specify:		Specify: White
Be Completed	15. Decedant's Education 16a. Dece	dant's Usuai Occupation	16b. Ki	nd of Businass/Industry
ple	(Spacify only highast grada complated) (Give lifa. Elemantary/Secondary (0-12) Collega (1-4or 5+)	kind of work dona during most of workir DO NOT usa ratired)	·g	
FO		stress	clo	thing
9	17. Fathar's Nama (First, Middla, Last)	18. Mother's Nama	(First, Middla, Maidan	Sumeme)
O	Maurice Baile	Ethel F	arver	
	19a. Informant's Name/Ralationship (Type, Print) 19b. Mailir	ng Addrass (Street and Number or Rura	I Routa Number, City o	r Town, State, Zip Coda)
r ta	Samuel M. Rakes - son 3520	Hawks Hill Rd., N	lew Windsor	MD 21776
any injury or other traumatic event, the Monce. To Be Comp	20a. Method of Disposition 20b. Placa of Dispo	osition (Nama of matory or other place)	Data 20c. Lo	cation - City or Town, Stata
y or			2/5/99 Lin	wood, MD
in a		Name and Address of Facility		
any in	Clark & D. Man	Ha	rtzler Fun	
	23a. Part1. Enter the disease, or complications that clused the deeth. Do not ent shock, or heart feilure. List only one cause or onch in the control of the	10 Church St., New		MD 21776 Approximata
as the bunal-transit	Saquantially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consection of the co			
	d			
clar				
y Physician/M	Part II Other significant conditions contributing to death but not resulting in the u	nderlying ceuse givan in Part I.		use contribute to the cause of death? No 3 Probably 4 Unknown
leted	Congestine Heart Failur		24a. Was an autoperformed?	24b. Wara autopsy findings eveilable prior to completion of causa of daath?
Be Comp			1 ☐ Yas 24	No 1 Yas 2 No
Ö	25. Was cesa rafarred to madicel	26. Placa of Death		
B	axaminar?	Other:	ma 5 Rasidance	6 Other (Specify)
tion: To	27. Manner of Death Value Panding 2 ER/Outpetier		28d. Describe how injur	
completely filled in by the tuner Medical Certification:	3 Suicida 4 Homicida 6 Could not be datarmined 28a. Place of Injury - At homa, farm, str building, atc. (Spacify)	aat, factory, office	28f. Location (Streat an City or Town, State	d Number or Rural Routa Number,)
edical C	29a. Certifier (Check only one) Cartifying Phyaiclan: To the best of my knowledga, death to the best of my knowledga, death and manner stated.	n occurred at the time, data and place, a vestigation, in my opinion, death occurred	and dua to the cause(s) ed at the tima, data and	and mannar as stated. d place, and dua to the cause(s)
completely filled in by the	29b. Signature and title of cegitier	29c. Licansa number	29d. Da	ta signed (Month, Day, Year)
	8/14/1/1/8	1 26516	0	Eb 5 1999
	34 Name and address of person who completed cause of death (Itam 23a) (Type.	Print) ANEY Ne 1	GRED W	21702
State	31. Data filad (Month, Day, Year) 32. Registrar's Signature			

FEB 0 5 1999

G. Sparks

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ALICE BLUE Harkins Flority Name of rock hashinton, power sever eval numbers Shady Crove Adventist Hospital Shady Crove Advent		[C	ertificate of	Death		Reg. No. 99		ole II
Shady Grove Adventist Hospital Shady Grove Adventist Hospital Shady Grove Adventist Hospital Shady Grove Adventist Hospital Social Security Nurries Shady Grove Adventist Shady Grove Grove Shady Shady Grove Adventist Shady Grove Grove Shady Shady Grove Grove Shady Shady Grove Grove Shady Shady Grove Grove Shady Shady Grove Grove Shady Shady Grove Grove Shady Shady Grove Grove Shady Shady Grove Grove Shady Shady Grove Grove Shady Shady Grove Grove Shady Shady Grove Grove Shady Shady Grove Grove Shady Shady Grove Grove Shady Shady Grove Grove Shady Shady				8					Y990r	3. Time of Death 2:40PM
Social Security Number S. Sex 7. Age (in year, least primate) Literate (1 Year, S. Months) Date (in Sign) December (1 Year) December (100		
313-12-8406 10 No. 2XF 88 North Days Hours Mr. (North Days Hours Mr. (North Days No. 10 No. 1				-			_			_
Description of Dispersion Third Little Third		1	M 2DF		Months Devs	Hours Min.	8. Date of Birl (Month, De	h y, Yeer) n 6 1010		
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14. Robert Businburgars. 04115 February 6,	Ped	one)	and manner steted.							
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)	2	29b. Signature end title of certifier			29c. Licen	se number		29d. Dete signed	(Month, De	y, Year)
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30. Name and address of person who completed cause of death (Item 23e) (Type, Print) H. KOBERT Brschlich 6320 Democracy Blvd Bether Buth		H. Kobert L	rschbach	632	o Dem	ocracy	Blud	. Bethe	3da	141)2

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #7,2/12/99,BMW,Montg.Co. Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month **Physician** Helen T. Harper February 9, 1999 3:00 PM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bedford Court Healthcare Silver Spring Montgomery 8. Data of Birth (Month, Day, Year) (March 8, 1904 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs. 9. Birthplaca (Stata or Foraign Country) Texas **Funeral** Days Hours 1 M 2 XF Months 94 -95 Director 578-60-7766 Usual Rasidenca of Decedant the Marylan 10a. Stata 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 X Yas 2 No Silver Spring Maryland Montgomery Directo 288-10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b must be 3701 International Drive 20906 United States Funeral Home: Race - Amarican Indian, Black, Whita, atc. 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ② No If Yas, Giva Was Decedent of Hispanic Origin? (Specify Yes or No-II Yas, specify Cuban, Maxican, Puarto Rican, atc.) 72 hours after Hygiena. other than "natural", or it went, the Medical Examin 1 Navar Married 2 Married Specify: Black Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working tifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) filled within Elemantary/Secondary (0-12) Collega (1-4or 5+) D.C. Public Schools Education permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: It faims 27 is marked other any injury or other traumatic event, 9008. 18. Mother's Nama (First, Middla, Maiden Sumama) 17. Fathar's Nema (First, Middla, Last) Be (unavailable) John Tyler Delia 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 5545 Oakman Blvd., Detroit, MI James H. Harper 20b. Placa of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Daurial 2 Cramation 3 Ramoval Irom Stata Maryland National Cem. 2/15/99 Laurel, Maryland 4 | Donation. 5 Othar (Specify) 21. Signature of Fungral Service Licensee 22, Nama and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, 20012 D.C. 23a. Pert1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in Seath) /Medical Congestive Heart Failure days Examiner Dua to (or as a consequence of): Examine Coronary Artery Disease years tially list conditions Dua to (or as a consequenca of): leading to immedia Enter Underlying (Disease or injury physician s the buria Box 68760 2 Physician/Medical Dua to (or as a consequence of): certificate 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 0.9 1 Vss 2 No 3 Probably 4 Unknown Respiratory Tract Infection, Atrial Fibrillation Records, þ Sign ad The law requires 24b. Ware autopsy lindings available prior to completion of cause of deeth? should 24a. Was an autopsy performed? Completed page 2 20 No 1 Yas 1 ☐ Yas 2 ☐ No of Vital Physician: 25. Was casa ralarrad to medical Be 26. Placa of Deeth (Check only ona) Hospitel: Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA this 27. Mannar of Death 28a. Data ol Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Division or Attending 1 X Natural 5 Pending invastigation n 24 hours after death.

• Funeral Director: Aft
pletely filled in by the fur 1 Yas 2 No 2 Accident 6 Could not be 28a. Placa ol Injury - At home, larm, street, lactory, office building, etc. (Specify) 3 ☐ Suicida 28I. Location (Street and Number or Rural Routa Number, City or Town, Stata) 2 4 Homicide 29a. Certifiar 1 🖄 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) end mannar es steted. Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigetion, in my opinion, death occurred at the time, date end plece, and due to the cause(s) and manner stated. 29c. Licanse number 29d. Data signed (Month, Day, Year) 29b. Signatura and little of confiller 9 mes D43202 February 9, 1999 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

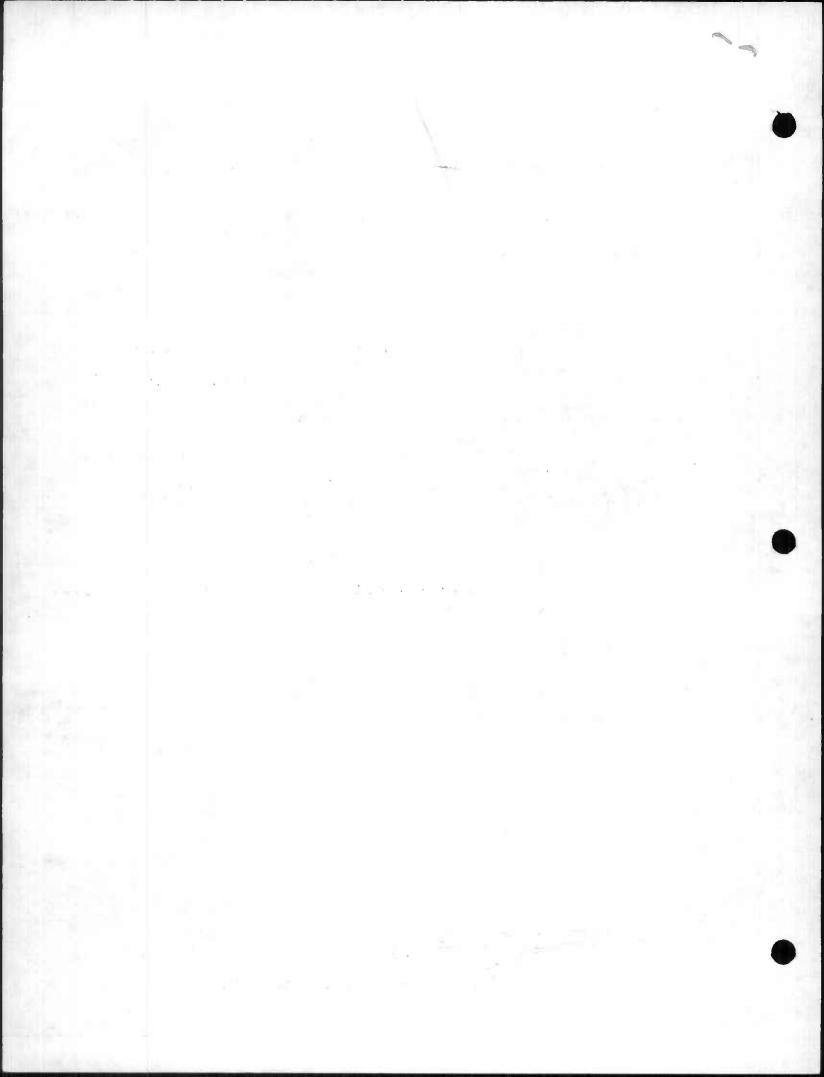
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B. Sparks

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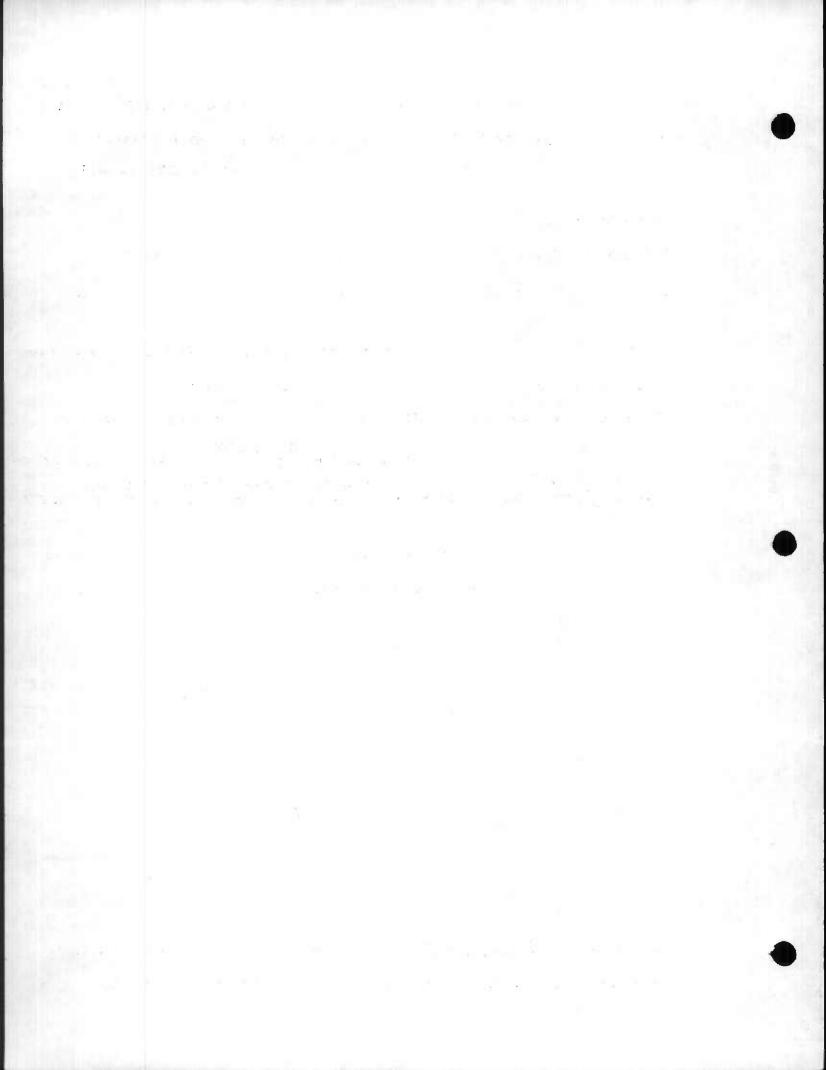
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	Certificate of Death Reg. No.							9 00413			
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/Medical Examiner	4a Facility Nama (If not institution, gir		LL L		4b. City, Town, or I		4c. County of		1141		
Examine	Wilson Health Ca	re Center			Gaithers	-	Mont	gomery			
Funeral Director		Sex 7. Age (In yrs 1 □ M 2 F 94	s. last birthday) Yrs.	If Under 1 Yea Months Days		8. Data of Birth (Month, Day, May 12	Year)	9. Birthplaca <i>(State or Fore Country)</i> Maryland	əign		
ore, Maryland 21215-0020 s. 1 and 2 should be filed within 72 hours etter deeth with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "naturel", or items 23s or 28s-1 show other treumstic event, the Maddal Evant are must be notified at To Be Completed by Funeral Director	Usual Rasidence of Decedent 10a, State 10b, County	100.0	City, Town or Lo	cation				10d. Inside City Lim	nits		
								1 X Yes 2 □ I			
	10e. Street and Number	10f. Zip Code				10g. Citizen of What Country?					
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	11. Marital Status 1 Naver Marriad 2 Marriad 3 Widowed 4 Divorced	Armed Forces? 1 Yes Stano If Yes Give		U.S. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto			Specify:				
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	Elementary/Secondary (0-12) College (1-4or 5+)			mbler	ed)		Electri	cal			
	17. Fathar's Name (First, Middla, Lasi	71330		18. Mother's Nam		t, Middla, Malden Surnama)					
	Tudor Heete			Jessie	9	Small					
	19e. Informant's Name/Relationship			19b. Mailing Address (Street and Number or Rural Route Num 8016 Fieldstone Drive, Frede							
	Virginia Dinterm							yland 21702 ity or Town, State			
O se of A	1 Burial 2 Cremation 3 4 Donetion 5 Other (Speci	(h) F	orest 0	sition (Name of matory or other pl a k Ceme1	tery 2			burg, Maryla	nd		
Baltim permit. Peg Department Important: It any injury o	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Maryland 20882 23. Part Empt th disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Intervel Between Interv										
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II Records, P.O. Box The law requires thet the death certain has been signed by the attendir page 2 should be datached for use Completed by Physiclan/A	Cerchia	/	24a. W.			es an autopsy informad? 24b. Were autop available procompletion of deeth?					
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within 2 on the comple	29b. Signature and the of certifier	and manner stated.		29c. Licer	nse number	2	9d. Date signed	(Month, Day, Year)			
	I See My D. 19294 Febru						Felmer	an 6. 1999			
10	30. Name and discuss of person who	completed cause of death (Ite	em 23e) (Type,	Print)	A	GAITHE	DE ALIAO	March Last 79	7		
State Registrar	31. Dete filed (Month, Day, Year) EFR 0 10	32. Registrar's Sign		Some	61	37 (11)K	-, ,,,	100 100/			

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State of Maryland / Department of Health and Mental Hygiene

Manual transportation in the property of the p	211-09-2565 Isual Residence of Decedant	ge Care & R Sex 7. Age	ehabil (In yrs. last b 8 10c. City, Tor German	itation irthday) If Un Monti	n Ctr	4b. City, Town, or Local Montgomery		4c. County	of Deeth Omery 9. Birthpl	5:40 AM lece (State or Foreign try) sylvania	
neral solution of other traumatic event, the Manager Parameter and Param	Montgomery Village Social Security Number 211-09-2565 Isual Residence of Decedant Oa. State 10b. County Saryland Montgome: 00. Street and Number 13948 Esworthy Royal Married 3	ya street end number) ge Care & R Sex 7. Age 7 Ty 12. Was Decedent E-Armed Forces? 1 1 1 1 Yes 2 No K 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ehabil (In yrs. last b 8 10c. City, Tor German	itation irthday) If Un Monti	n Ctr	4b. City, Town, or Local Montgomery	village	4c. County	of Deeth Omery 9. Birthpl	r lece (Stete or Foreign try)	
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206	13948 Esworthy Ro	12. Was Decedent E Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give	var in II S	10f.						1 ☐ Yas 2 No	
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17.	12	ducation ada com <i>pleted</i>)	16e. Decedent's Usuel ((Give kind of work			during most of working	,	16b. Kind of Business/Industry			
17.		College (1-4or 5+	4or 5+)		gn Service Office			United :	State	s Governmen	
206	7. Fether's Nema (First, Middle, Last	")		0		18. Mother's Neme (Maiden Surnam	e)		
206	Richard Hermesma	an				Katherine	ne Gross				
206	19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing				Address (Street and Number or Rural Route Number, City or Town,				, State, Zip Code)		
21.	Ricardo Leo Hern	mesman/Son	12	512 Carr	ington	Hill Drive,	Gaithers	sburg, Ma	rg, Maryland 20878		
23	20b. Method of Disposition 1 A Burlel 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) 20b. Plece of Disposition (Neme of cematary, crametory or other plece) Feb. 9, Gate of Heaven Cemetery						1999	20c. Location - City or Town, State Silver Spring, Maryla:			
r dis	Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-28 23a. Part I. Entar than isseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest, Approximate Intervel Between Onset and Daath Immediate Ceuse (Finel disseese or condition resulting in deeth) Chronic Renal Failure e. Chronic Renal Failure Due to (or es e consequence of): Generalized Atherosclerosis 5 Years									Approximate Intervel Between Onset and Daath	
Tas ras	Sequentielly list conditions, if eny, leeding to immediate cause. Enter funderlying Cause (Disease or Injury thet initieled events rasulting in deeth) Last Due to (or es e consequence of): C. Dua to (or es a consequence of): d.										
Per	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.						23b. Did tobacco use contribute to the cause of deeth				
by Physician/M							1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknow				
Completed			24					en eutopsy med?	ave	ere autopsy findings eileble prior to mpletion of cause deeth?	
200							1 □ Y	es 2NNo	1 🗆	Yes 2□ No	
	5. Wes case referred to medical exeminer?					26. Plece of Deeth (Check only or	ne)			
25. O C 27.	1 Yes 2 No	Hospitel: 1 ☐ Inpatien	t 2 ERV	Outpatient 3	DOM	her: 4 X Nursing Home	e 5 🗆 Resid	ence 6 Oth	er (Specif)	r)	
	7. Menner of Deeth 1 Neturel 2 Accident 3 Suicide 6 Could not b	(Month, Dey	28e. Dete of Injury (Month, Dey Yeer) 28b. Time of Injury M 28c. Injury et Work? 1 Yes 2 No						red		
Sertifi	3 ☐ Suicide 6 ☐ Could not be determined								I Route Number,		
29									eted. tha cause(s)		
1007	29b. Signeture end title of certifiar 29c. License number					se number	29d. Date signed (Month, Day, Year)			Day, Year)	
71	9b. Signeture end title of certifiar		D33443								
30	9b. Signeture end title of certifiar	1000	m		D33	3443	T.	shruary	1.	1999	
A State 31.	9b. Signeture end title of certifiar 0. Neme end eddress of person who	completed cause of dea	eth (Item 23e	(Type, Print)	D33	3443	F	ebruary	4,	1999	



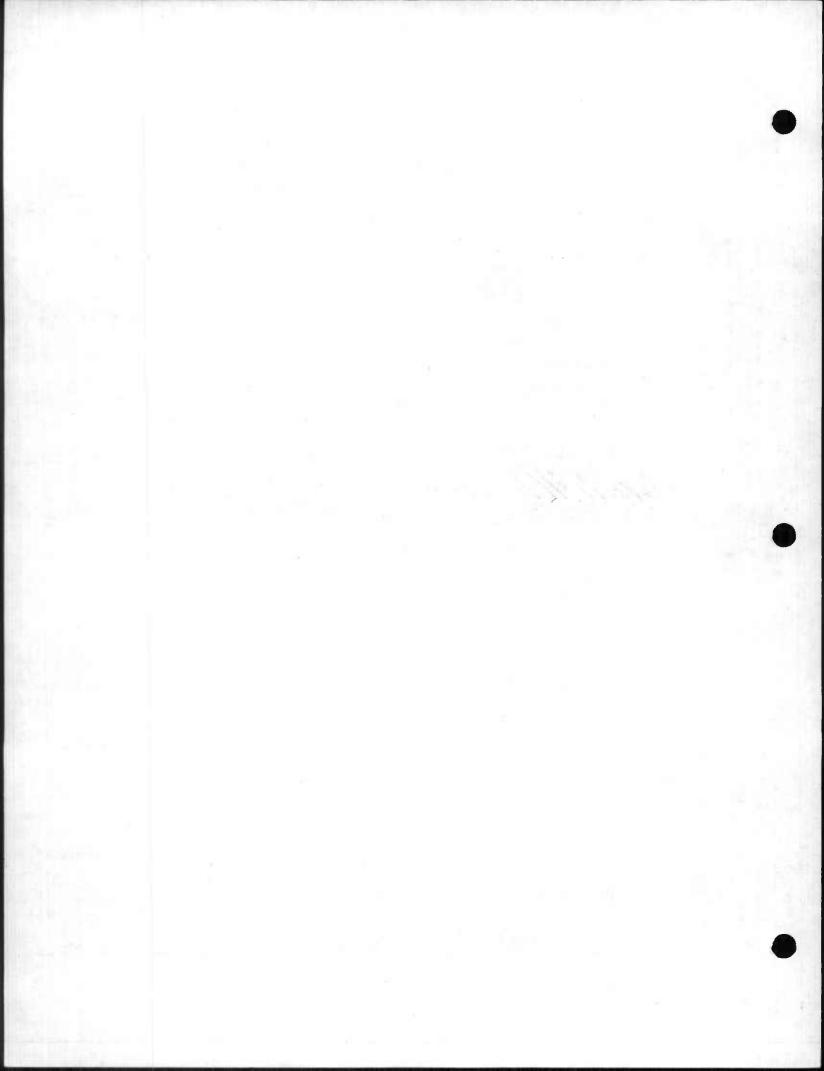
State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Lillian Mitchell Hill -EBRU 4c. County of Death /Medical 4s Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 8. Dete of Birth (Month, Day, Year) Sept. 2,1914 If Under 24 Hrs. If Under 1 Year 5. Sociel Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2 F Months Hours 223-10-3075 84 Director Virginia Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 733 Sligo Avenue 20901 death Funeral United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Merital Stetus o filed within 72 hours after if Hygiene. other than "netural", or ite 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: P "natural". 3 Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Medical Nurse 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fill.
Department of Health and Mental Hy
Important. If fam 27 is marked oth
any injury or other traumatic avant Be Roscoe Mitchell 0 Lillian Davis 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores Bondurant, daughter 7923 - 14th St. N.W., Washington, D.C. 20012 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 Buriel 2X Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Chesapeake Crematory 2/10/99 Beltsville, Maryland 21. Signature of Funeral Service Rices 22. Name and Address of Fecility McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediete Ceuse (Finel Rug CARdiAL INFARCTIO Acuté disease or condition resulting in death) **Examiner** Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or es a consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed TOBACCO ABUSE 1 Yes 20KNo certificata 1 Yes 2 No GASTRIC or Attending Physician: 25. Wes case referred to medical examiner? Be 28. Place of Death (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No Medical Certification: To this 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 24 hours after deeth. Funeral Director: After 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 2 4 ☐ Homicide filled in Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier completaly (Check only one) within 2 \$ 29b. Signeture end title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. N.W. Washington D.C. KA. ATHUR 106 32. Registrar's Signeture 31. Dete filed (Month, Day, Year)

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State

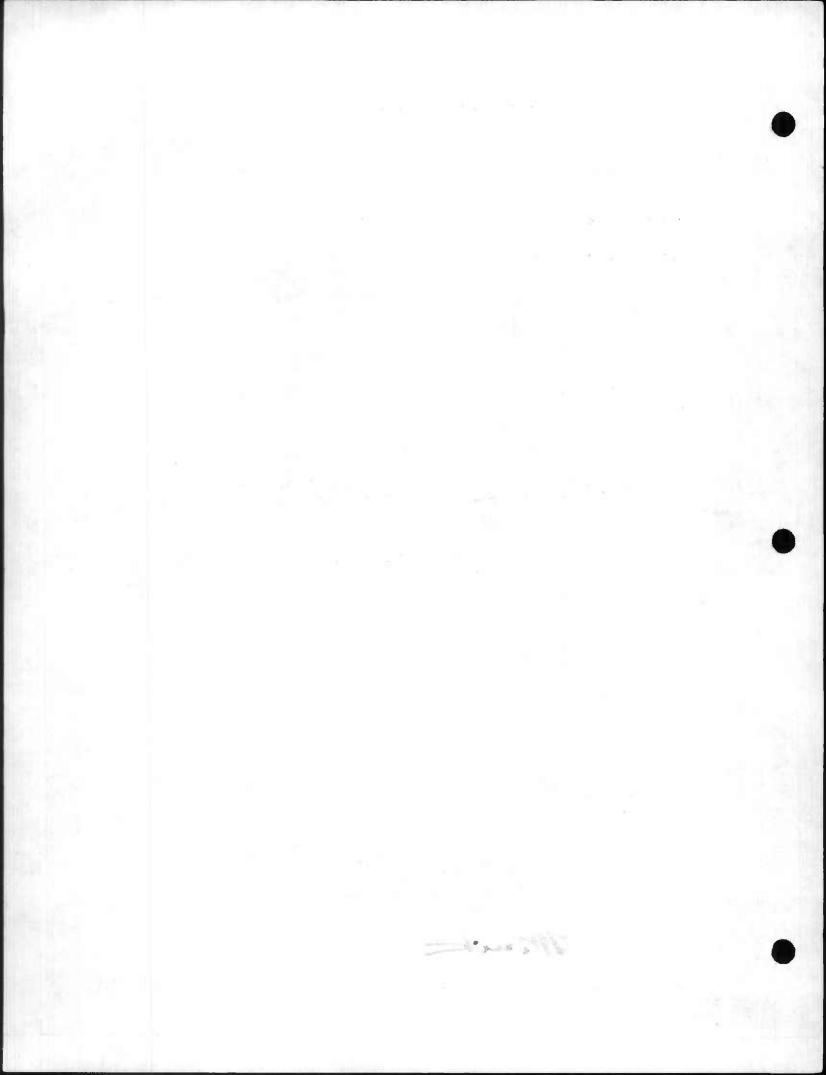
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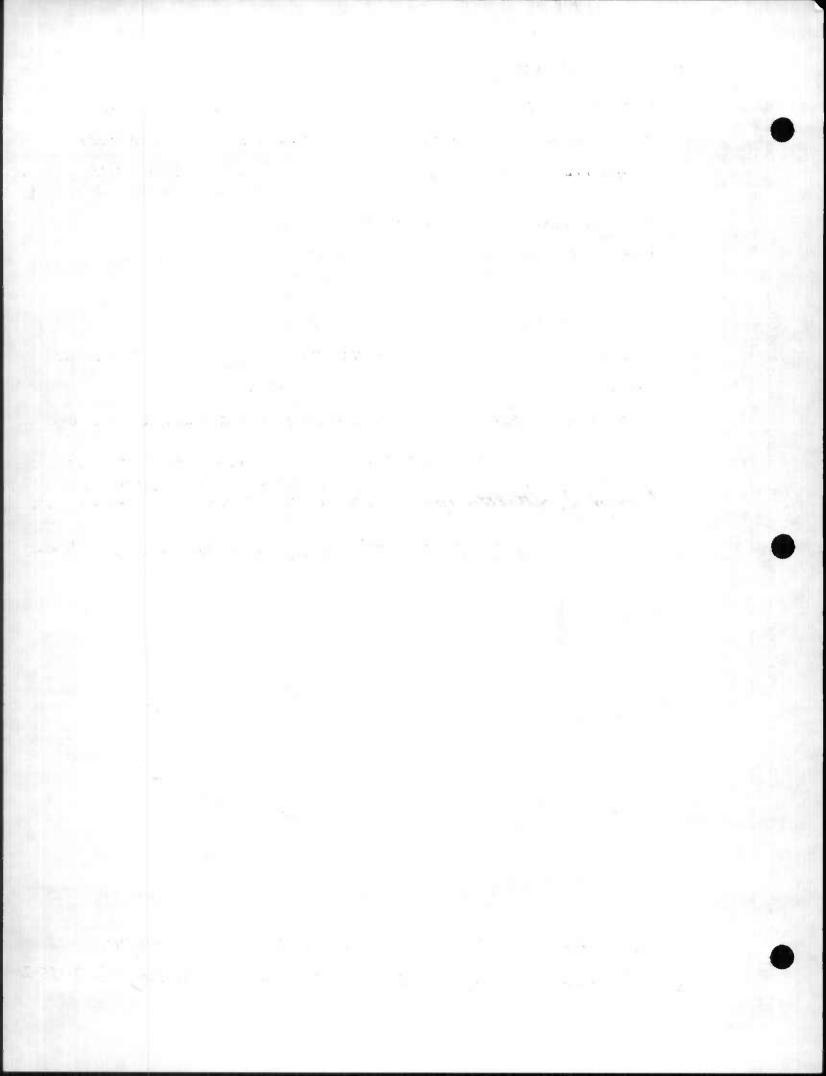


State of Maryland / Department of Health and Mental Hygiene

	Decedent's Neme (First, Middle, Las.	2)	Certifica	te of Death	2. Date of Dea	leg. No.	3. Time of Deeth
Physiciar	The state of the s	" Della Christi	ine Horman		Month	Dey Ye	ear
/Medica	A. Fastin Name off and invite size of a		the norman		Location of Death	y 7, 1999 4c. County of I	
Examine	2504 Jennings Ro			Silver		Montgon	
Funeral	5. Social Security Number 6. Se			r 1 Year If Under 24 Hr	S. 8. Date of Birth		Birthplace (State or Foreign
Director	215-46-3668	□M 21XF 52	Yrs. Months	Deys Hours Mir	8. Date of Birth (Month, Day Nov. 30	,1946 N	(aryland
with the Maryland a or 28a-f ahow the notified at	10a. State 10b. County		y, Town or Location		7		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
vith the Ma or 28s-f	Maryland Montgor	nery Si	lver Sprin			0.000	
Air Mark	10e. Street and Number			p Code		log. Citizen of Wha	
23g	2504 Jennings Ro			1902		United St	American Indien,
11215-0020 within 72 hours after death with the Maryland ane, then "natural", or Items 23a or 28a-f ahow he Medical Evantines must be notified at		12. Was Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Deck If Yes, spo	dent of Hispanic Origin? (cify Cuban, Mexican, Pue	rto Rican, etc.)		White, etc.
5-00 72 hours natural.	15. Decedent's Edu		16a Decedent's Usi	nel Occupation		16b. Kind of Busin	
21215-0020 ed within 72 hours at yorine. yor then "netural", or t, the Medical Exam	(Specify only highest grad	le completed)	(Give kind of w lifa. DO NOT	iel Occupation ork done during most of wi use retired)	orking		
d 212 filed within Hygiene. ther than int, the M	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	Minister	of Music/Tea	cher	Church M	usician/Music
ind be filed tal Hygin		J			ame (First, Middle,	Maiden Sumame)	
Vian Vid be Mental Mental Mental	Christopher T.	Estes		Della	C. Sumr	ners	
	19e. Informant's Neme/Relationship (7)		19b. Meiling Addres	s (Street and Number or F			nte, Zip Code)
CZNF	Amy Horman Smith	(daughter)	408 St. L	awrence Driv	e. Silver	Spring,	MD 20901
0 - I E S	20a. Method of Disposition		Nace of Disposition (Na emetery, crematory or		Deta	20c. Location - City	
	1 Burial 2 Cremetion 3 4 Donation 5 Other (Specify,	demover from State	esapeake Ci		2-8-99	Reltsvill	e, Maryland
ortan	21. Signeture of Funeral Service Licens	11	-				e, mary rana
Baltimo permit. Page Department of Important: If any injury or once.	Deen H	Rapp		nd Address of Fecility Funeral Servi st Avenue,			20910
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that ceused the death ne cause on each line.	n. Do not enter the mo	de of dying, such as cardi	ac or respiratory en	rest,	Approximete Intarvel Batween
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a. <u>Metastatic</u> Due to (o	Ovarian Ca				Onset and Death
idate be executed physician and is the burial-transit		b Due to (o	res a consequence of	:			
5 0 6		C Due to (or	r as a consequence of)				
death certification of for use a							
O & 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Pert II. Other significant conditions co	ntributing to death but not resu	ulting in the underlying	causa given in Part I.			bute to the cause of death?
\$ 50 E					- 101	7as 200 No 3	□ Probably 4 □ Unknown
aw requ		1.70%			24a. Was a perfor		24b. Wara autopsy findings available prior to completion of cause of death?
The in					1 D Y	es 2 🕅 No	1 ☐ Yes 2 No
ysicien: Thy second control of the Co	25. Was case referred to medical				eath (Check only o	na)	
Of VITA Physician: this certific ral director,		Hospital: 1 Inpatient 2	ER/Outpatient 3□ □		Homa 510 Resid	ence 6 Other	(Specify)
After fune		28a. Data of Injury (Month, Day Year)	28b. Tima of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe h	ow injury occurred	
Division (Hospital or Attending P 24 hours after death. Funeral Director: After to stely lilled in by the funeral Cartellossion.	3 Suicide 6 Could not be detarmined	28e. Place of Injury - At he building, etc. (Specify	ome, ferm, street, fecto	ry, office	28f. Location (S City or Tow	itreet and Number on, State)	or Rurel Route Number,
Hospi 14 hou Funer tely lill		sician: To the best of my know iner: On the basis of axaminat and manner stated.					
Vithin 2 To the Comple		no d	29	c. License number		29d. Dete signed (#	Month, Dey, Year)
66	1	Buit		11506		February	8, 1999
	30. Name and address of person who o	ompleted cause of death (Item	23a) (Type, Print)				
	Frederick P. Smith			avenue, NW.	Washing	ton, DC	20015
State	31. Dete filed (Month, Day, Year)	32. Registrar's Signa	ture ,		-		
Registrar	FEB 0 9 1999	- Line	W. MO	acker			

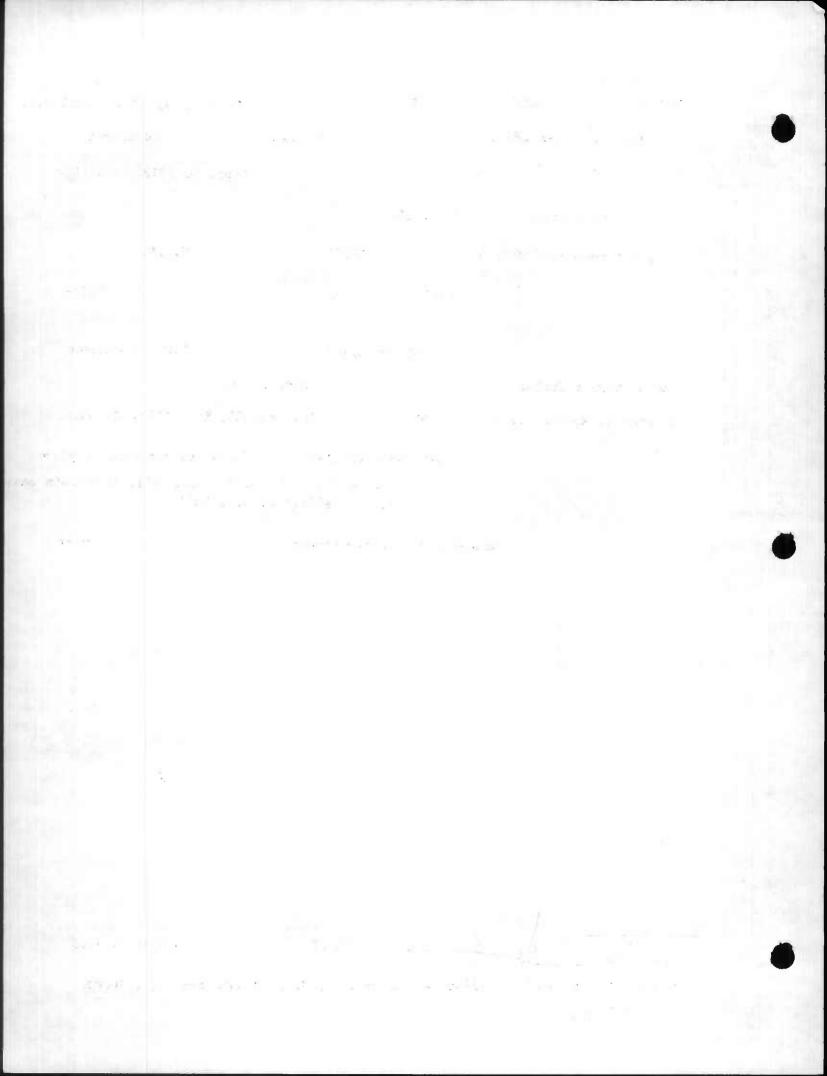


_	Item: 5 per F.H G-76 1. Decedent's Neme (First, Middle,			Certificate	of Death	2. Dete of D	Reg. No.	3. Time of Death
ician dical	FLORENCE HORO					Month FEBRU	ARY 10, 1	feer
iner	4e Facility Name (If not institution, HEBREW HOME (ACHTNOR	ON		or Location of Dea		
ıl 💮			(In yrs. last birtl	nday) If Undar 1 Y	ROCKVI Feer If Under 24 Hours M	Irs. 8. Date of Bin. (Month, D	irth ley, Year)	GOMERY 9. Birthplece (State or Foreign Country)
r	Usuel Residence of Decedent	XX	92 Y	13.		MAY 10	, 1906	WASHINGTON, D.C
	10a. Stete 10b. County		10c. City, Town	or Location				10d. Inside City Limits
Director	MD. MONTGO	MERY	ROCK	VILLE				1 ☐ Yes 2 ☐ No XX
	10e. Street and Number			10f. Zip Co			10g. Citizen of Wh	
Funeral	6111 MONTROS	12. Was Dacedant E			of Hispanic Origin?	(Specify Yes or N	U. S.	A Americen Indian,
ρ	1 □ Never Merried 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	Armed Forces?		If Yas, specify	Cuban, Mexican, Pu	èrto Rican, etc.)	Black,	Whita, atc. WHITE
eted	15. Decedent's (Specify only highest	Education grede completed)	16a.	Decedent's Usual O (Give kind of work d	ccupation one during most of v	vorking	16b. Kind of Bus	iness/Industry
Completed	Elementery/Secondery (0-12)	College (1-4or 5-		life. DO NOT use n	etired)			
e Co	12 YEARS 17. Fether's Name (First, Middle, La	est)		RETAIL	SALES 18. Mother's N	Neme (First, Middle	e, Maiden Sumeme,	ES APPAREL
To B	MOSE PACH				ANN	IE GARNE	R	
	19e. Informent's Neme/Reletionshi				treet end Number or			
	JOYCE CAPLAN	- NIECE				_		MD. 20852
	20a. Method of Disposition XX Buriel 2 Cremetion 3 4 Donetion 5 Other (Spa		cemetery	Disposition (Name of cremetory or other T_LEBANON)	r plece)	2/12/99		MARYLAND
	21. Signeture of Funeral Service Li	Stattle	neuer	DANZANSK	ddress of Fecility Y-GOLDBER			S, INC. ARYLAND 20852
edical Examiner	23a. Part1. Enter the disease, or c shock, or heert failure. List or Immediate Ceuse (Finel disease or condition resulting in deeth)	Arter		rotio a		1		Interval Between Onset and Death
Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury	b	Due to (or es e c	onsequence of):				
//Medical	that initieted events resulting in deeth) Lest	c	Due to (or es a co	onsequence of):				
iciai	Pert II. Other significent condition	contributing to death bu	t not resulting in	the underlying caus	e given in Pert I.	23b. Die	d tobacco use cont	ribute to the cause of death?
by Physician/M	Dementing				.	10	Yes 2010	3 Probably 4 Unknown
Completed							is en eutopsy formed?	24b. Were eutopsy findings eveilabla prior to completion of ceuse of deeth?
Com						1	Yes 28 No	1 ☐ Yes 2 ☐ No
Be	25. Wes cese referred to medicel exeminer?	Hospitals				Death (Check only	one)	
- T	1 ☐ Yes 2 ☑ No 27. Menne of Deeth	Hospitel: 1 Inpatier					sidence 6 Other	
tion	1 Naturel 5 Pending	28a. Dete of Injun (Month, Dey tion	Year) In	jury M	Injury et Work? 1 Yes 2 No		1-7	
Certification:	3 Suicide 6 Could no determin	28e. Plece of Inju- building, etc.	ry - At home, far (Specify)	m, street, factory, of	fice		(Street and Numbe own, Stete)	r or Rurel Route Number,
edicai	29a. Certifier (Check only one) 1 ✓ Certifying 2 ☐ Medical Ex	Physician: To the best of taminer: On the bests of and mannar stat	examinetion end	/or Investigation, in	my opinion, deeth or	ccurred et the time	e, date end plece, er	nd due to the ceuse(s)
M	29b. Signatura and titla of certifiar	-MS		29c. Li	cense number 23958 those R	,	29d. Date signed	(Month, Dey, Year)
	30. Name and address of person w	no completed ceuse of de	eth (Item 23e) (Type, Print)	trose R	d. Pol	levs 16	MD 20852
State	31. Date filed (Month, Dey, Year)	32. Registre	r's Signeture	4 h	- V-1			



State of Maryland / Department of Health and Mental Hygiene 9 051

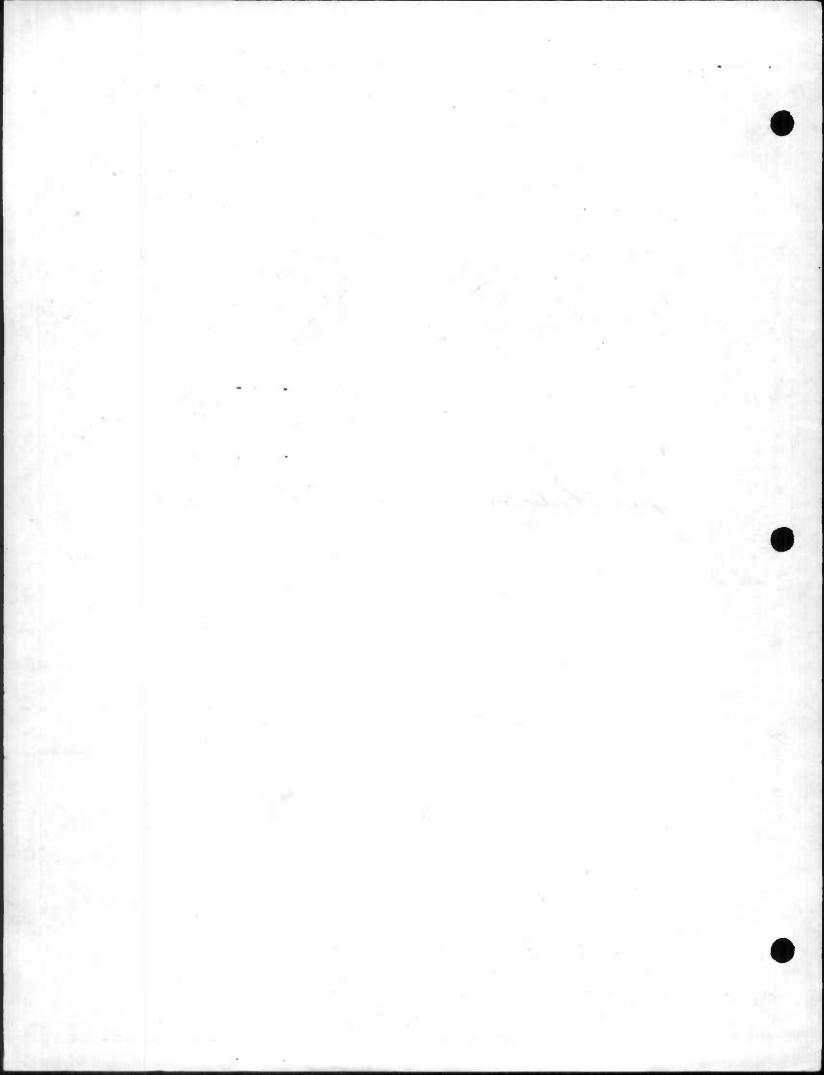
			Ce	rtificat	e of L	Death		Re	g. No.		
Physician /Medical	Decedent's Name (First, Middle, Last, Grover Don	nald	Hughes					2. Dete of Death Month Februar		99	3. Time of Death 3:30 а.п
Examiner	4a Facility Neme (If not Institution, give 5901 Montrose Road		1			b. City, Tov		ation of Deeth	4c. County Mon	of Death	ery
uneral irector	3.0 10 1.0	7. Age (In y	rs. last birthday) Yrs.	If Under Months		If Under 2 Hours	Min.	8. Dale of Birth (Month, Dey, Sept. 10	Year) , 1918	9. Birthp Cour CAFI.	place (Stete or Foreintry) FORNIA
al, or items 23s or 28s-f show Evant net must be notified at by Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD Montgomes	_	City, Town or Lo	ocalion						1	0d. Inside City Limi 1 ☑ Yes 2 ☐ N
23a or 28a-f a last be notified al Director	10e. Streel and Number 5901 Montrose Road	d #N1205		10f. Zip	Code 852				Og. Citizen of V U.S.A.	Vhat Cour	ntry?
leted by Funeral	11. Marilal Stetus 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 ☐ No W Year, Give Year or Dates:	WII	Was Deced If Yes, spec 1 ☐ Yes	cify Cuba	spanic Orig n, Mexican Specify:	in? (Spec , Puerto P	cify Yes or No- lican, etc.)		k, White,	cen Indien, etc. White
metic event, the Medical I	15. Decedent's Edu (Specify only highest grade Elementery/Secondery (0-12)	e completed) College (1-4or 5+)		dent's Usua kind of wo DO NOT us		alion lu <i>r</i> ing most)	of workin		U.S. GO		
other traumatic event, the Madical To Be Completed	17. Father's Name (First, Middle, Last) Cecil Everett Hugi		Meteo	TOTOS				(First, Middle, Mastner			morro
T Table	19a. Informant's Name/Relationship (Ty Suzanne C. Wochos		19b. Meili 5901	ng Address Montr	(Street e	Rd.,	r or Rural #N12	Route Number, 05, Roc	City or Town, kville,	Stete, Zip MD	20852
any injury or other tra	20a. Method of Disposition 1 Spurial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from Stale	o. Place of Dispo cemetery, cre Rest Hav	metory or c	ther piec	,	2/		agerst		own, State Maryland
as the bunal-transit as the bunal-transit	Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last	Metasta Due to	eath. Do not en atic Pro o (or as a conse	ter the moderate of the state o	de of dying	g, such as	on, D	respiretory arre	16 isi,		Approximate interval Between Onsel end Deeth years
detached for usa	Part ti. Other significant conditions con	ntributing to death but not	resulting In the u	underlying o	ause give	en in Part I.					o the cause of dea
2 should be pleted by				447 20 147				24a. Was al perform	n autopsy ned?	24b. W	dere autopsy finding valleble prior to impletion of cause death?
irector, page 2 s	25. Was case referred to medical					26. Place	of Death	(Check only on			
F -	examiner? 1 Yes 2 No 27. Manner of Death 1 Noture 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Dey Year	ER/Outpatie 28b. Time of Injury		28c. Injun	4 LI NU	2	ne 5 Reside 8d. Describe ho			fy)
ed in by the funer Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Placa of injury - A building, etc. (Sp.	it home, farm, st	reet, factor	y, offica		2	18f. Location (St. City or Town		ber or Rur	al Route Number,
pletely fill edical		recien: To the best of my ser: On the bake of exam and manner steted.									
W.	29b. Signature and title of certifier			D	c. License				9d. Date signe bruary		
State Registrar	30. Name and address of person who oc Edward Gelmann, M. 31. Date filed (Month, Day, Year) FEB 0 8 199	.D. 3800	Reserve		oad,	N.W.	, Was	shington	n, D.C.	200	07



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death #26 PER PHY G768 2-22-99 WR. Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Deeth Month **Physician** 1999 Alma Louise Harmison Feh 6 /Medical 4e Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner' Washington County Hospital Hagerstown Washington If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth (Month, Days Hours Min. | 2 - 25 - 1919 Birthplace (Stete or Foreign Country)
 PA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2♥ F Vrs 79 Director 213-10-5684 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or itema 23s or 28a-f ahow the Medical Examinar must be notified at 1 Yes 2 No Director Morgan Berkeley Springs WVa 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 304 S. Green St. 25411 Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck. White, etc. hours efter 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Merried 2 Merried 1□ Yes 2 No altimore, Maryland 21215-0020 Specity: Specify: à 3€ Widowed 4 Divorced White "neturel" Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) 12 Seamtress other permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If Item 27 is marked other any Injury or other traumatic avanta 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Elwood Douglas Bertha Alma Hess Ira 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Intorment's Name/Relationship (Type, Print) Dixie Mason Rt. 4 Box 7100, Berkeley Springs WV 25411 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremetion 3 Removel from Stete 4 □ Donetion 5 □ Other (Specify) 2-9-99Berkeley Spgs WV Greenway Cemetery 21. Signature of Fa nesal Service Lidensee 22. Name and Address of Facility Hunter-Anderson Funeral Home -106 Mercer Berkeley Springs WV S. 25411 234 Just Center the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tailure. List only one ceuse on each line. Approximate tntervel Between Onset and Death Physician /Medical Immediate Cause (Final Deac diseese or condition resulting in death) all Examiner Due to (or es e consequence of): physician end s the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence ot): gaugrene Box 68760 certificate be Physician/Medical Dee to (or as a consequence of) 980 Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown b 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was en eutopsy performed? Completed Deed page 2 1 Yes 2 0 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Be 25. Was case reterred to medical exeminer? 26. Place of Deeth (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After To the Mospital or Attending within 24 hours after deeth. To the Funeral Director: After Naturel 5 Pending 1 Yes 2 No Investigation 2 Accident 6 ☐ Could not be 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and menner es stated. completely 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner steted. (Check only 29d. Dete signed (Month, Dey, Year) 29b. Signeture and title of certitier 29c. License number MO Vaus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hill Ave, Hagerstown Md 21742

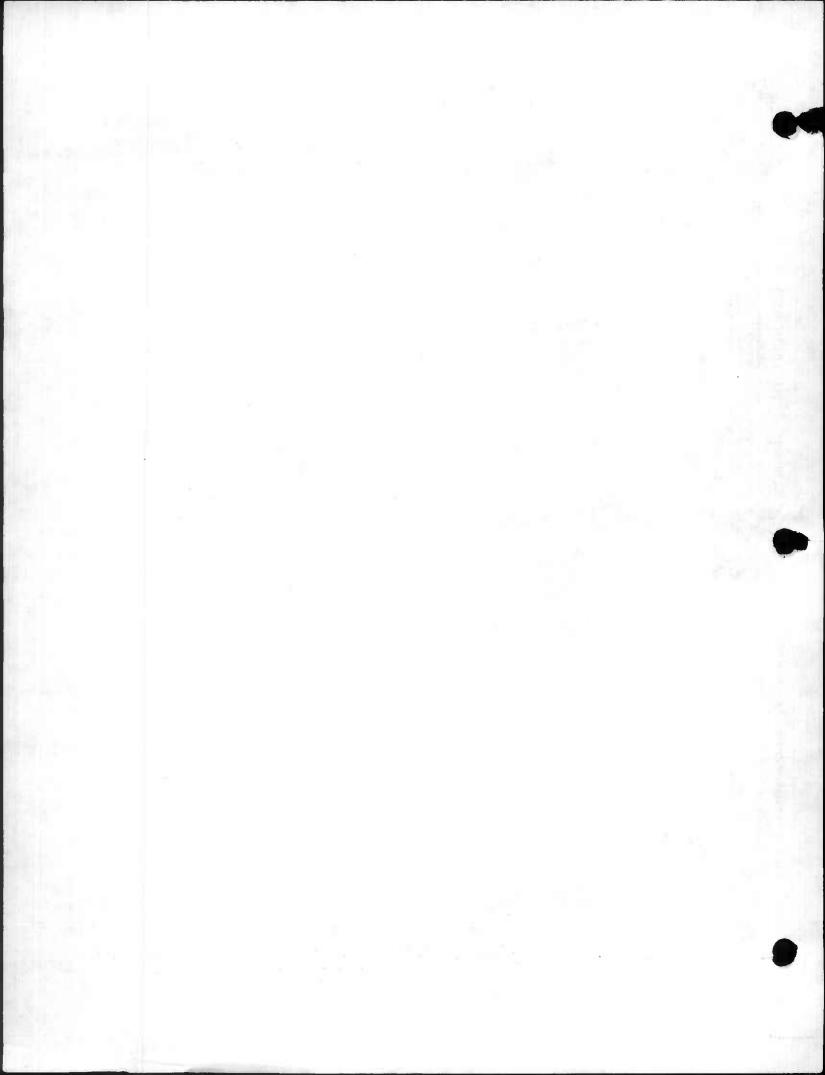
State Registrar 31. Dete filed (Month, Day, Year) 32. Registrar's Signature FEB 1 6 19 9 9

B. Spark



State of Maryland / Department of Health and Mental Hygiene 00 051.20

				Certifica	ate of	Death		Reg. No.	J U.	14.20
hysician	1. Decedent's Name (First, Middle, L.	est)					2. Data of D	eath Dev	Year	3. Tima of Death
edical		Norma B.	Ilg				Februa	ry 6, 19		10:15 AM
miner	4e Facility Name (If not institution, gi	ve street and number)				4b. City, Town	, or Location of Dea	th 4c. County	of Death	
	3 Brighton Ter	race				Gaither	sburg	Mont	gomery	
eral			yrs. last birth	Month	der 1 Year		Hrs. 8. Dete of Bi	rth ev Yearl	9. Birthplac	e (State or Foreign
tor	402-48-1320 Usual Rasidence of Decedent	1□M 2\\ F 6	2 Y	rs.	Days	riodis	July 29	9, 1936	Ohi	o o
by Funeral Director	10a. Steta 10b. County	10	c. City, Town	or Location					10d	. Inside City Limits
to	Maryland Montgo	mery	aither	sburg					1.4	Yes 2□No
Directo	10e. Street and Number				Zip Code			10g. Citizen of	What Country	n
	0 7 4 1				00077			Tim i to	3 C+++	
ere	3 Brighton Terr	12. Wes Decedent Eve	r in U.S.	_	20877 cedent of I	Hispanic Origin	? (Specify Yes or N	-	d State	
Funeral	1 Never Merried 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ No		If Yes, s	pecify Cub	an, Mexican, F	Puerto Rican, atc.)	Ble	ck, White, etc	
by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□ Yes	2⊠ No	Specify:		Specif		
	15. Decedent's E	10.11	16e I	Decedent's U	sual Occui	nation		16b. Kind of B	Whit	
Completed	(Specify only highest gr	ade completed)	1 (Give kind of life. DO NOT	work done	during most of	f working			
E	Elementary/Secondary (0-12)	College (1-4or 5+)	Ноп	nemaker	-			Own H	ome	
ŏ	17. Father's Name (First, Middle, Las)				18. Mother's	Neme (First, Middle			
Be c	Ralph E. Barker					Flizs	beth Mey	are		
2	-		106	Mallian Addr	(01				State Zin C	a da 1
	19a. Informant's Name/Relationship					and Number (or Rural Route Numi	oer, City or Town	, SIBIB, ZIP CI	ooa)
	John C. Ilg	(husband)	20b. Place of I	me as			Dete	200 Leasting	City or Tour	State
	1 Burial 2 □ Cremation 3 [cemetery	crematory o	or other pla	(08)		20c. Location		
	4 Donetion 5 Other (Speci	(y)	Forest	Lawn	Cemet	tery	2-12-99	Erlange	er, Ken	itucky
	21. Signeture of Funerel Service Lice	nsee Rac	0	Rapp	Fune		vices, P.		2001	
	23a. Pert1. Enter the disease, or con shock, or heart failure. List only	polications that caused the	death Dono				Siler Sp			pproximata
Jer Jer	Immediata Cause (Final disesse or condition resulting in death)	aUrothelia	al Cano		of):				- 17	year
edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury that initiated events	C	to (or as a co						1	
2	resulting in death) Last	d.	to (or es a co	insequence o	n):				1	
Icia	Part II. Other significant conditions	contributing to death but n	ot resulting in	the underlying	n causa di	ven in Pert I	23b. Dic	tobacco use co	entribute to the	he cause of death?
/ Physician/								Yes 2∏ No		bly 4 Unknown
Completed by								s en eutopsy ormed?	availe	eutopsy findings able prior to pletion of causa ath?
mc								Vac alla		
	25. Wes casa referred to medical					00.00		Yas 2 No	101	res 2)(No
Be C	axaminer?	Hospital:			0	hor	Death (Check only			
. To	1 ☐ Yes 2 ☐ No 27. Menner of Death	1 Li Inpatient	2 ER/Out		DUA	4 LI Nursi	ing Home 5 🖾 Res			
ation	1 CNetural 5 Pending 2 Accident investigation		er) 28b. Ti	me of jury M	28c. Inju Wo 1	nyat ork?]Yes 2□No	The street of th	how injury occu	1180	
Certification:	3 ☐ Suicide 6 ☐ Could not to detarmined		At home, ferr Specify)	n, street, fect	ory, offica			(Street and Num own, State)	ber or Rural F	louta Number,
edicai		nysician: To the best of m miner: On the basis of exa and manner stated	mination and							
M	29b. Signeture and the of certifier	1		- 2	29c. Licen	se number		29d. Date signe	ed (Month, Da	y, Year)
	121	1/	01	2	D.	35990	0	Februar	v Q 1	999
	30. Name and address of person who	completed frames of draw	(Item 22a) (7	ione Drive)						
							ng, MD 209		0	
State	31. Dete filed (Month, Day, Year)	URRELL, M. 32. Registrar's					-0, 110 20,			
State	FFR 0 0 10		w 1	9 1	DAL V	4				



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** JOSEPH KENNETH INSCOE February 1999 9:18 A.M. 10 /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda If Under 24 Hrs. Hours | Min. Suburban Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1X M 2□ F 726-14-6147 Director October 9,1926 North Carolina Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or frame 23s or 28s-f show the Weddell Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? *natural", or items 23a 10007 Thornwood Road 20895 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 13 Yes 2 □ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 Specify: White 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Pharmacologist Food & Drug Adm, permit. Pages 1 and 2 should be filed to Department of Haalth and Mentel Hygie Important: If Item 27 is marked other to 17. Fether's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Linwood St. Clair Inscoe, Sr. Nannie Lee McIntyre 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) May N. Inscoe/Wife 10007 Thornwood Rd., Kensington, Md. 20895 20e. Method of Disposition
1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Date 4 ☐ Donation 5 ☐ Other (Specify) 2/15/99 Alexandria, Va. Metropolitan Crematory 21. Signature of Funeral Service Licensee 22 Name and Address of Facility VIENNA FUNERAL HOME, INC. 171 W. Maple Ave., Vienna, Va. 22180 eal 23a. Part1. Enter the disease, or complications that caused the disease. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** ROSPINATIONY FAILURE /Medical Immediate Cause (Final diseese or condition resulting in death) Examiner SYSTEME TURIMATURY RISPONST SYNDOM Examiner physician and the burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest WILLATER Physician/Medical Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown signed t P 24b. Were autopsy findings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? 1□Yes 20No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: 12 Propatient 2 PR/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2K No Certification: To 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation Neturel 1 TYes 2 TNo 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 124 hours after d e Funeral Direct pletaly filled in by 4 Homicide vo the Hospital or within 24 hour To the Far 152 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. 29e. Certifier edicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 000527

State Registrar

DHMH 16 Rev 6/95

10

8600 Old Georgetown Rd., Bethesda, Maryland 20814

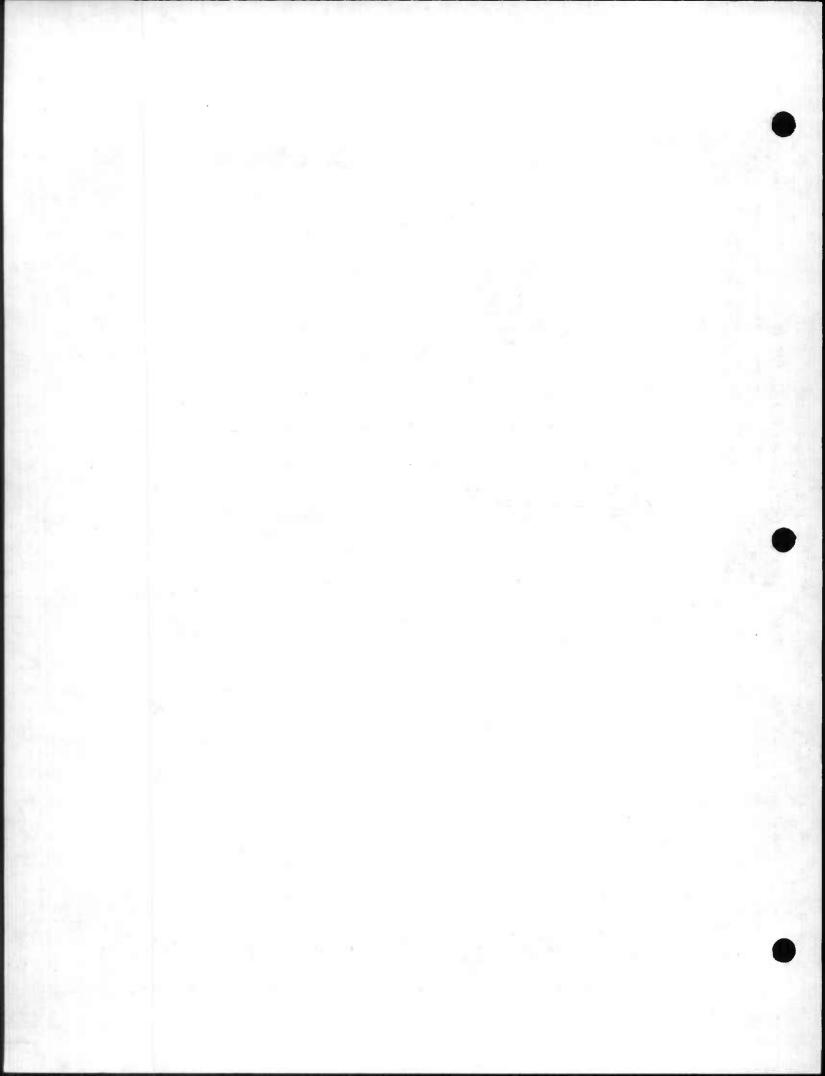
30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signeture

Leo Ratello, M.D.

FEB 12

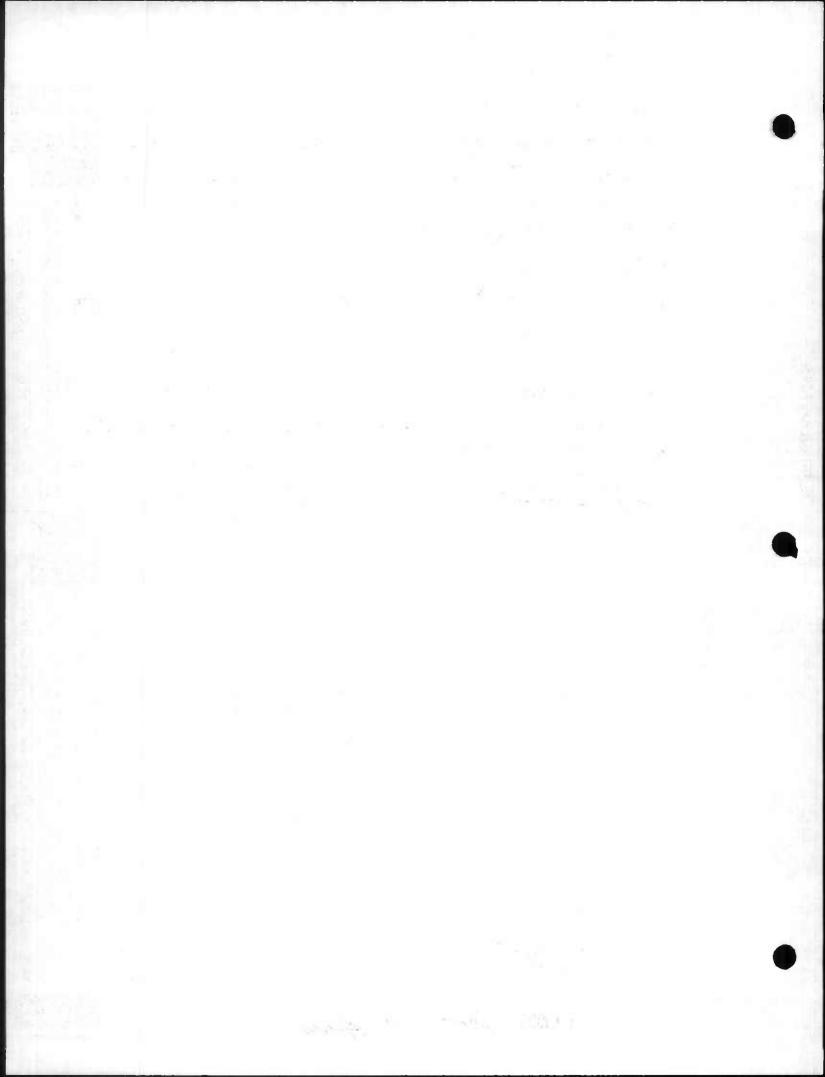
31. Dete filed (Month, Dey, Year)



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State of Maryland / Department of Health and Mental Hygiene 9 0 5 1.2 2

					,	Cer	rtifica	te of	Death		F	Reg. No.	eur ^y	
		П	1. Decedent's Neme (First, Middle, L.	st)							2. Data of Dea	ith	V	3. Time of Death
	Physici /Medi		Lois Meel	kins Jo	hnson						Month	Day 5	Yaar	5:00A
1	Examir		4a. Facility Name (If not institution, gi	va street and number	7)				4b. City, To	wn, or Lo	cation of Death	4c. Co	unty of Death	1
			Dorchester Ger	neral Hos	pital				Cambr	idge		D	orches	ter
	Funeral Director		217-30-8546	Sax 7. A 1□M 2 K F	ga (In yrs. last b	irthday) Yrs.	If Unde Months	Days		Min.	8. Date of Birth (Month, Day Dec. 12,	, Year)	9. Birth Con Mar	nplaca (Stata or Foreign untry) yland
	aryland show	_	Usual Rasidance of Decedant 10a. State 10b. County		10c. City, Tov	vn or Lo	cation							10d. inside City Limits
	Sea-1	5	Maryland Dorches	ster	Camb	ridg	•							15XYes 2□No
	# P P	Director	10e. Street and Number				10f. Zij	Coda			1	10g. Citizan	of What Cou	intry?
	ath v	ig.	P.O.Box 1095	T 12 121				613					SA	
5-0020	within 72 hours after death with the Maryland ilene. Then "natural", or Items 23a or 28a-f show the Medical Exeminer must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forcas 1 Yes 2 if Yes, Give Year or Dates	?) No	1	Was Dece f Yes, spe 1□ Yes				ecify Yes or No- Rican, atc.)		Raca - Amer Black, Whita ecify: B	
O	2 ho	P P	15. Decedent's E	ducation	168	a. Deced	lent's Usu	ai Occu	pation			16b. Kind o	of Business/f	ndustry
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	# T T T	Ö	17. Father's Name (First, Middle, Las	7)		Dead		uli	18. Mothe	er's Name	(First, Middle,			ПОР
Maryland	should be nd Mental marked o	ToB	George H. Meel	rine Sr					н	olon	0. Ph	illin		
ary	shound M	-	19a. informant's Name/Relationship		19	b. Maliin	ng Addras	s (Stree			al Route Numbe		wn, State, Z	ip Code)
	nd 2 alth a 27 is		Enez Grubb, execu	ıtive		816	Brad	1ev	Ave.	Cam	bridge,	Maryl:	and 21	613
e,	-IE		20a. Method of Disposition		20b. Place	of Dispo	sition (Na	me of		Jan			ion - City or T	
Ē	Pages net of nt: if its iry or o		1 Burial 2 □ Cremation 3 0 4 □ Donation 5 □ Other (Speci		Ð		Ceme		,	12	/9/99	Comba	idaa M	aryland
aitimore,	permit. Pages Department of Important: If if any injury or once.		21. Signature of Funeral Service Lice		рес		-		ass of Facili		13133	Campr.	rage, m	aryrand
ñ	SOFES						Benn		Smith			Home	01/01	
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	Physician		snock, or near failure. List only	one cause on aach	lina.								į	interval Batween Onset and Death
7	/Medical Examiner		immediate Causa (Final disease or condition resulting in death)	: Mila	marie	1	lur	g	Ca	ne	er.			momin
	be sit	iner	H	- Pul	Dua to (or ss s	conseq	L e	ml	50 liè	m	(POSS	5,66	2)	days.
o,	death certificate be executed e attending physician and of for use as the burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury	Res	Due to (or as s	and the last of		He	rile	er	٠.			mins.
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ROX	attendin	an/M		d. 10-011	wisul	Lu	a	The	nece	w	acce			1000
	dea he att	Physician/	Part ii. Other significant conditions	contributing to death	but not resulting	in the ur	nderlying	ausa gi	ven in Part I		23b. Did to	obacco use	contribute	to the cause of death?
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0	ath. :: Afte	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Invastigation		ay Year)	Injury	M		rk?]Yes 2□	No				
UNISION	i or Attending P affer death. Director: Affar i d in by the funen	IIIC	3 ☐ Suicide 6 ☐ Could not be determined	20e. Place of Ir	jury - At home, f	arm, stre	eet, factor	y, office			28f. Location (S City or Town		umber or Ru	ral Route Number,
5	s after	Certification:	4 - Hollings	building, a	(c. (Specify)					1	Ony of Yow	ri, State)		
	To the Hospital or within 24 hours after To the Funeral Dir completaly filled In	edical	29a. Certifiar 1 Certifying Pr (Check only one) 2 Medical Example	nysician: To the best miner: On the basis of and mannar s	of examination as	e, death	occurred	at tha t	me, dste an opinion, dea	d pisce, th occurr	and due to tha c ed at tha tima, d	ausa(s) and lata and pla	d manner as ca, and due	stated. to the cause(s)
	ro th romp	Me	29b. Signature and title of certifier				29	c. Licen	se number		2	29d. Date si	gned (Month	, Day, Year)
			1/4//	///	40		7	56	987			215	199.	
			30. Name and address of person who	complated cause of	4 - 7000	(Type, I	Print)		we	cī	Cann	bno	elac	MO21613.
			31. Date filed (Month, Day, Year)		rar's Signature								0	
	Sta Registr				Personal Department	E	9.	loo	1.1					

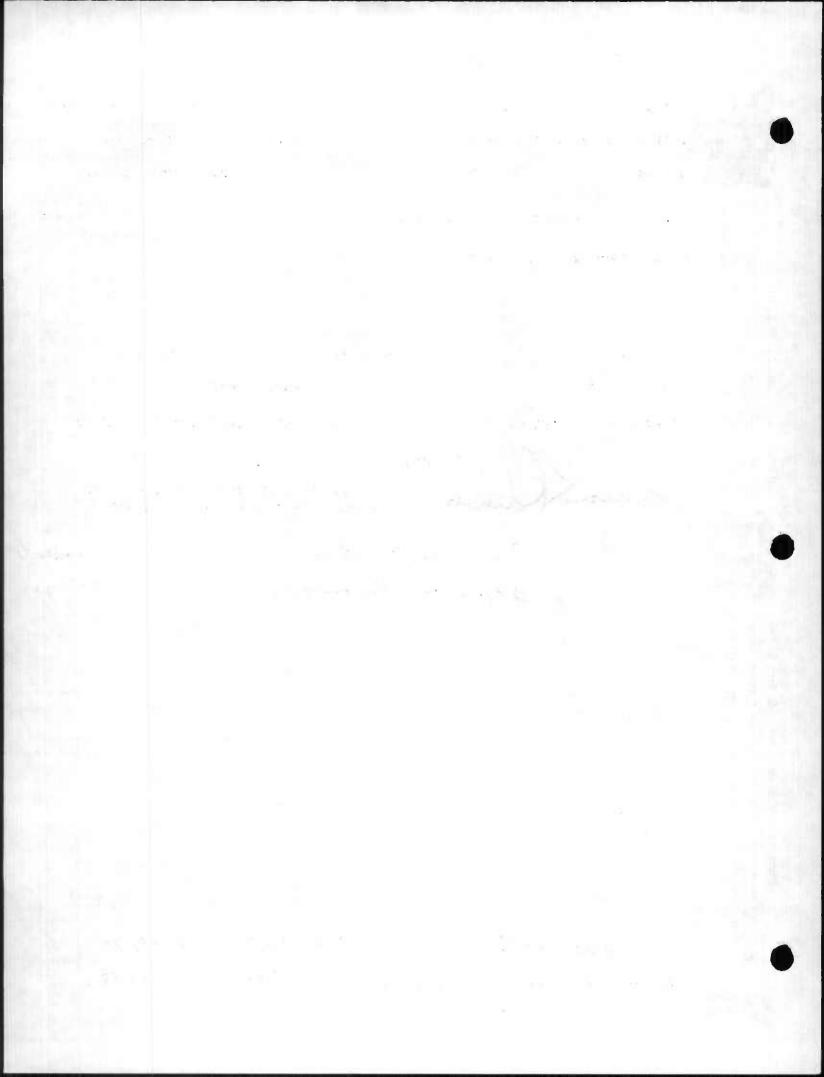


State of Maryland / Department of Health and Mental Hygiene 9 05423

Certificate of Death

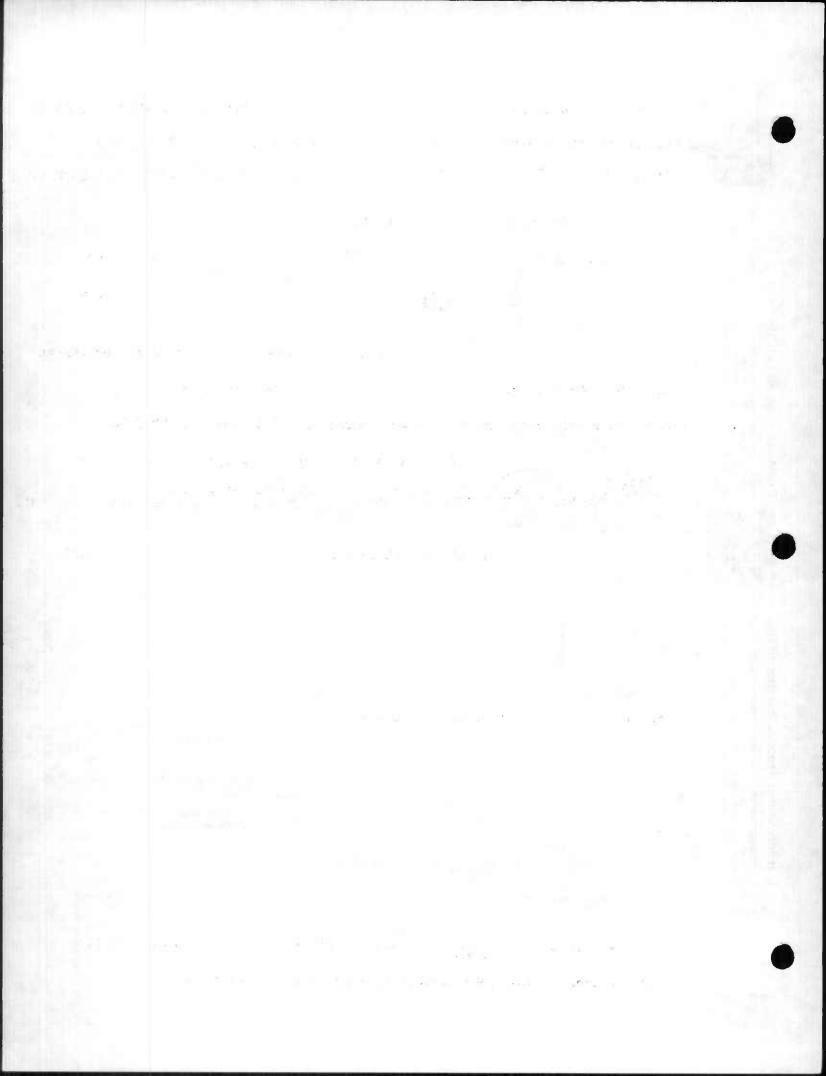
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					Cei	rtificate	e of	Death		E-S	Reg. No.		
Physician		ame (First, Middle, Li			1					2. Date of De Month	Day	Year	3. Time of Death
/Medical	Sophie		Jewler								ary 9,		1:25pm
Examiner		o (If not institution, gir lome of Gr			n			Rocky	ville	cation of Death		of Death gomen	у
Funeral Director	5. Social Security 578-54-2		Sex 1 □ M 2KD F	7. Age (In yrs. la 99	st birthdey) Yrs.	If Under Months	1 Yeer Days	If Under Hours	24 Hrs. Min.	8. Date of Bin (Month, De Feb. 5	th y, Year) , 1900	9. Birthi Coul Russ	place (State or Foreign http:) 13
3	Usual Residence	of Decedent		10c. City	Town or Lo	cation							Od. Inside City Limits
Be-f sho	MD	Montgom	ery		hesda								1 ☐ Yes 2 ☑ No
or 2 Dire	10e. Street end N					10f. Zip					10g. Citizen of	Whet Cou	ntry?
er, or items 23a or 28a-f show Examiner must be notified at by Funeral Director	11. Maritel Status 1 □ Never Me 3 ☑ Widowed	Testlake T s erried 2□ Married I 4□ Divorced	-	edenf Ever in U,S rces? 20 No				ispenic Ori an, Mexicar Specify:	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	- 14. Rac Bla	SA ce - Americ ck, White, y: Whit	
natur edical	(Sp	15. Decedent's E pecify only highest gra- condery (0-12)	ducation ade completed) College (1	-4or 5+)	(Give life.	dent's Usue kind of wor DO NOT us	k done e retired	du <i>n</i> na mos	t of work	ing	16b. Kind of B		dustry
Se set	17. Fether's Nem Jacob	e (First, Middle, Last Snider)		но	use W	ire			(First, Middle,	Own Ho		
7 is m traum		Name/Relationship									er, City or Town		
if Item 2 or other	20a. Method of D			State car	ce of Dispo	sition (Nem	e of			Date	20c. Location	- City or To	
Important: if Item 2 any Injury or other other.	_	n 5 Other Speed	1	DC L	Da		ky-0	Goldbe	y erg N	lemoria	l Chape	ls, I	
ding physician and se es the buriel-trensit Medical Examiner	Sequentially list if eny, leading to cause. Enter Un Cause (Disease this treatment of the cause) and the cause (Disease the cause of th	nts	b. Dee	Due to (or a	as e consec	juenca of):	ml	rosi	7				romedical
by the etten eched for us thysician	Part II. Other sign	nificant conditions	d	eath but not result	ing in the u	nderlying ca	ause giv	en in Pert I		23b. Did	_/		o the cause of death
been sign should be leted by											an eutopsy ormed?	6/	dere autopsy findings valleble prior fo ompletion of cause death?
page 2										10	Yes 2 PNo	11	☐ Yes 2☐ No
s certificete director, pag fo Be Co	25. Was case ref	erred to medical						7	e Deat	n (Check only	one)		
this raid		5 Pending	28a. Date (Mont	-	R/Outpatier 28b. Time of Injury		8c. Injur Wor	412 N			denca 6 □Oti how injury occu		fy)
To the Funeral Director: Affect completely filled in by the funeral Medical Certification:	3 Suicide 4 Homicide	6 ☐ Could not b	28e. Place	of Injury - At hon ng, etc. (Specify)	ne, farm, str	eet, factory	, office			28f. Location (City or To		ber or Run	el Route Number,
To the Funeral completely filled Medical C	29a, Certifier (Check only one)	1 Certifying Pi 2 Medical Exa	miner: On the ba										
To the Funeral Completely filled	29b. Signature et	nd title of cartifier	cm					e number	58		29d. Dete signo 2/10	ed (Month,	Dey, Year)
	30. Neme and ad	Idress of person who	completed caus	e of death (Item :	23a) (Type,	Print)	se.	Pal,	Poza	Kn7Le	mp 2	085	2
State Registrar	31. Date filed (M	FEB 1 2 19	32. R	e strar's Signatu	J.	de	rock	2					



State of Maryland / Department of Health and Mental Hygiene

		Certifica	ate of	Death	F	eg. No.	D 0 8 C
rsf)					2. Date of Dea		3. Time of
ı, Jr.							
a street and number)				4b. City, Town, or	Location of Death	4c. County	
Silver S	pring			Silver S	pring	Montg	omery
Sax 7. Ag	e (In yrs. lesf			If Undar 24 Hrs.	8. Data of Birth	Yaer)	9. Birthplaca (Stefa o
1MM 2LIF	74	Yrs.	is Doys	Tiours IVIII.	June 14	, 1924	Washington
	10c. City, To	own or Location					10d. Insida Ci
Georges	Seat	t Pleasa	nt				1 💢 Yes
		10f.	Zip Code			l0g. Citizen of W	Vhet Country?
eet		2	0743			United :	States
12. Was Decedent	Ever in U,S.	13. Was De	cedent of h	Hispanic Origin? (S	pecify Yes or No-	14. Rece	e - American Indian, k, White, etc.
1 X Yes 2 If Yes, Give Yaar or Datas:	No						Black
		6e Decedent's II	suel Occup	pation		16b. Kind of Bu	isiness/Industry
ade completed)	F.,)	(Give kind of life. DO NO)	work done Tuse retire	during most of world)	rking		
College (1-40)	0+)	Print	ing M	lanagemen	t	Federa	1 Governme
)				18. Mother's Ner	me (First, Middle,	Maiden Sumem	e)
n. Sr.				Jennie	Alexande	r	
(Type, Print)	1	9b. Mailing Addr	ess (Street				Stete, Zip Code)
orney in	Fact	9200 Edw	ards	Way #704	. Adelnh	1. MD 20	0783
	20b. Plece	of Disposition (/	Neme of		Dete		City or Town, Stete
Removel from State					2/0/00		
	Chesa				2/9/99	Beltsv:	ille, MD
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contributing to death b	ut not resultin	y in trie underlyin	y cause gr	ven in Paπ I.			-
Cardiova	scular	Disease			10,	res 2LINO	3 Probably 4.
					24a Wes	en eutonsv	24b. Were eutopsy
							evellable prior completion of
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Hospitel: 1 Inpati	ent 2 ER	Outpatient 3	DOA Ot	her: 4 X Nursing I	Home 5 Resid	lence 6 Oth	ar (Specify)
28e. Dete of Inju	ry Year) 28		28c. Inju	iry et ork?	28d. Describe h	ow injury occurr	red
n (NOTH), De	,	M					
28e. Plece of In building, el	jury - At home c. (Specify)	, farm, street, fec	tory, office		28f. Location (S City or Tow		per or Rural Routa Nun
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	Georges 12. Was Decedent Amed Forces? 12. Was Decedent Amed Forces? 12. Was Decedent Amed Forces? 12. Was Occupied (1-4 or 1) 13. Sr. Type, Pint) 14. Corney in 15. ACUTE 16. ACUTE 16. Cardiova: 16. Cardiova: 17. Ag 18. ACUTE 19. Cardiova: 18. Cardiova: 19. Cardiova:	a street and number) Silver Spring Ax To Age (In yrs. lest To Age (In	Silver Spring Silver Spring To. Age (In yrs. lest birthday) Monti	a street and number) Silver Spring Six 7. Age (In yrs. lest birthday) H Undar 1 Year Months Days 10c. City, Town or Location Seat Pleasant 10f. Zip Code 20743 12. Was Decedent Ever in U.S. Agned Forces? 12 Yes 2 No 1944 1 Yes, specify Cut 14. Yes 2 No 1944 1 Yes 2 No 10 Yes 2 No 1 Yes 2 No 10 Yes 2	a street and number) Silver Spring Silver Spring To Age (In yrs. lest birthday) And Corp. To Age (In yrs. lest birthday) To Age (In yrs. lest birthy and	Month Silver Spring Months Deys Hours Min. Min. Month Silver Spring Ab. City, Town, or Location of Death Ac. County Silver Spring Ab. City, Town, or Location of Death Ac. County Silver Spring Montg Ac. County Montg Silver Spring Montg Ac. County Montg Silver Spring Montg Ac. County Montg Silver Spring Montg Ac. County Montg Silver Spring Montg Silver Spring Montg Spring Sprin	



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #7, 2/11/99, BMW, MontggCo. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Day Phyllis Rising Johnson February 9, 1999 4:15 AM 4e Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 5301 Westbard Circle #211 Bethesda Montgomery if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (Stete or Foreign Country) Months Hours Devs 1 ☐ M 2 🖫 F 98 Yrs. 99 578-44-9518 April 14, 1900 England Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 X No Maryland Montgomery Bethesda 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5301 Westbard Circle #211 20816 United States 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Stetus 1 Yes 2 No
If Yes, Give
Yaer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 Widowed 4 □ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Nurse Hospital 17. Father's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Robert Watts Wellington Rising Jesse Margaret Dunn 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 2354 Tumbletree Way, Reston, Virginia James F. MacDonald/Executor 20191 20b. Plece of Disposition (Neme of cometery, cremetory or other place) February 10, 1999 20e. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 X Cramation 3 ☐ Ramoval from State

Physician /Medical

Physician

/Medical

10a. State

Examiner

Funeral

Director

r 28a-f show notified at

than "natural", or items 23s or

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mentat hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event, its Mental Evarance page.

Baltimore, Maryland 21215-0020

Direct

Funeral

by

Completed

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4 ☐ Donetion 5 ☐ Other (Specify)

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21 Signat

the Maryland

death with

for use es the signed by the s certificate hes b Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certifica funeral director.

Records, P.O. Box 68760,

Division of Vital

Examine physicien end s the buriel-transit thet the death certificate be executed

Examiner Physician/Medical by Completed 25. Wes case referred to medical exeminer? Be 2 27. Menner of Deeth Certification:

22, Name and Addrass of Fecility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M00846 7557 Wisconsin Avenue, Bethesda, Maryland 20814-2805 23a. Part I Entar tha disaasa, or complication, that causad the death. Do not entar the mode of dying, such as cerdiac or respiratory arrast, shock, or heert feiture. List only on the on each line. Approximate Intervel Between Onset end Deeth immediate Ceuse (Finel Arteriosclerotic Heart Disease diseese or condition resulting in deeth) 20 Years Plus Due to (or es a consequenca of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated avants resulting in deeth) Lest Due to (or es e consequence of): Dua to (or es a consequance of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the causa of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Hypertension 24b. Were autopsy findings eveileble prior to 24e. Wes an eutopsy completion of causa of death? 1 ☐ Yes 2 🖾 No 1 ☐ Yas 2 ☐ No

Montgomery Crematorium,

Inc.

26. Plece of Deeth (Check only one)

Other: 4 ☐ Nursing Home 5 K Residence 6 ☐ Other (Specify)

28d. Describe how Injury occurred

4 - Homicide 29a. Certifier (Check only one)

1 N Yes 2 No

1 XNeturel

3 Suicide

2 Accident

1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner es steted.

2 Medical Examinar: On the basis of axaminetion and/or investigation, in my opinion, death occurred et tha time, date end pieca, and due to the cause(s) and menner stated. 29b. Signeture end title of certifier

28a. Dete of Injury (Month, Day Year)

29c. Licansa number

D0013187

28c. fnjury et Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month. Dav. Year)

February 9, 1999

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Bethesda, Maryland

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

Neill Kennedy, M.D., 5530 Wisconsin Avenue #1240, Chevy Chase, Maryland 20815-8816

Registrar

3

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Medi

24 hours

To the Hosp within 24 hou To the Fune completely fil

1999

5 Pending

Investigation

6 Could not be determined

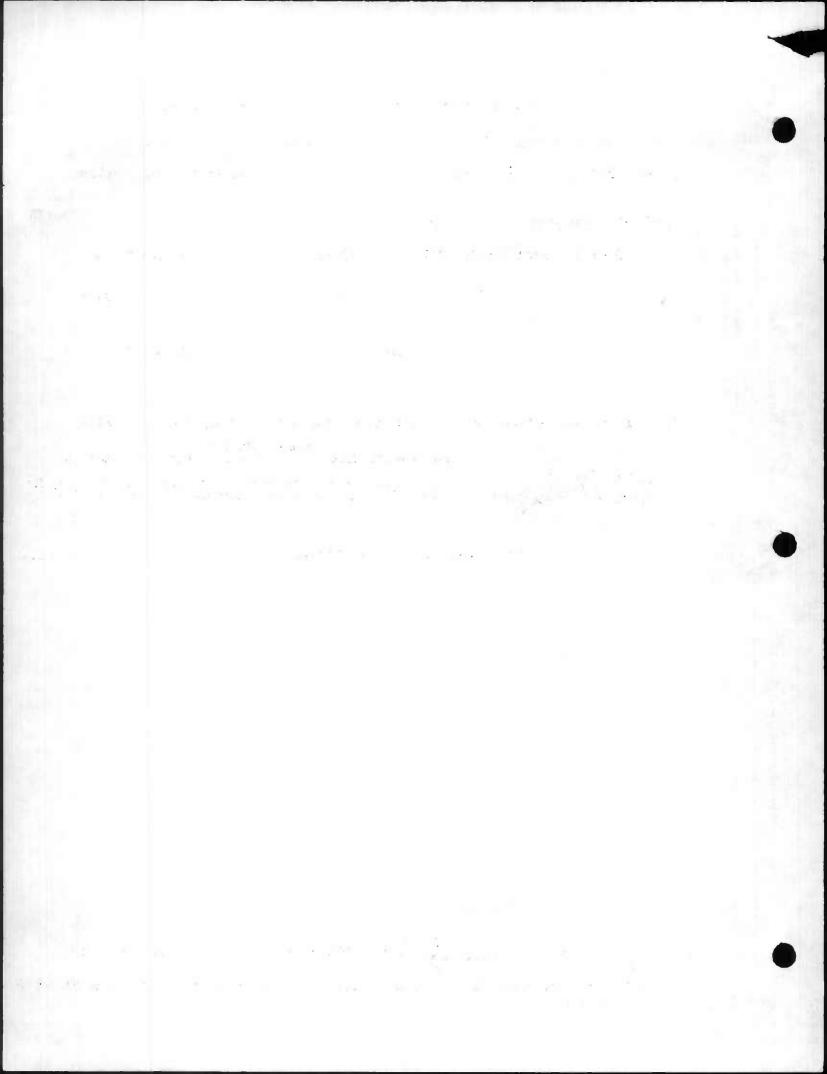
32. Registrer's Signature

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

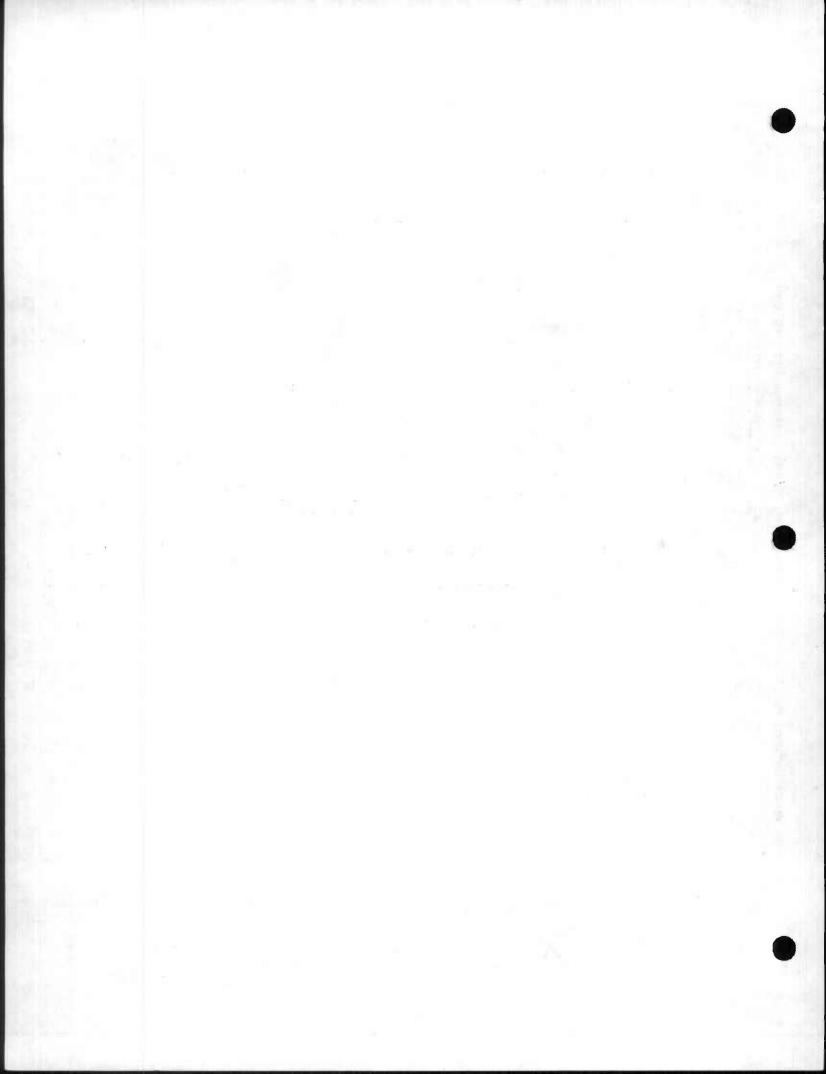
28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

porker



State of Maryland / Department of Health and Mental Hygiene

			C	ertificate o	f Death		Reg. No.	05426
	1. Decedent's Neme (First, Middle, Las	1)		THE PARTY.		2. Date of Do	eeth Day	3. Time of Death
Physician /Medical		C. Don Jon	nes			Februa		
Examiner	4a Facility Neme (If not institution, give	street and number)			4b. City, Town,	or Location of Dea	-	
Funeral Director	7209 Chestnut Str 5. Social Security Number 6. Se 526-20-6701			y) If Under 1 Yes Months Day			Montgo rth ey, Year) 1, 1924	mery 9. Birthplace (State or Foreign Country) Ohio
8 8	Usuel Residence of Decedent 10a. Stete 10b. County	100 0	ity, Town or	Lanation				10d Inside City Limit
the Maryland 28a-f show notified at ector	Maryland Montgome		evy Ch					10d. Inside City Limit
DI PRO ID	10e. Street and Number 7209 Chestnut Str	eet		10f. Zip Code 2081.			10g. Citizen of W United	
5-0020 72 hours after death v natural, or flams 23a dical Examiner mast	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW	u,s. 13	3. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☒ N	ıban, Mexican, Pu	(Specify Yes or Ne erto Rican, etc.)		- American Indien, k, White, etc. White
Seat Market	15. Decedent's Edi		16a. Dec	cedent's Usual Occ ve kind of work don	upation	wadina	16b. Kind of Bu	siness/Industry
Maryland 21215-0020 of 2 should be filed within 72 hours at the and Mental hygiene. This marked other than "natural", or traumatic event, the Medical Exam To Be Completed by F	Elementary/Secondary (0-12)	College (1-4or 5+)	Dip1	. DO NOT use reti	red)	VOIKING		Service/ ept. of State
be file tal Hyg d othe event,	17. Father's Neme (First, Middle, Last)		1 F -		18. Mother's N	lame (First, Middle	, Maiden Sumem	9)
ylar Wents Ments wheels wife en	Don Edgar Jone	es			Lorett	ta Genie	ve Kend	a11
ary should have	19a. Informent's Name/Reletionship (T		19b. Me	iling Address (Stre	et and Number or	Rural Route Numb	per, City or Town,	State, Zip Code)
M Salta	Margriet Spier	(wife)	Sa	me as 10				
Baltimore semit. Pages 1: Department of Hs mportant: If then my injury or oth- ance.	20a. Method of Disposition 1 Burial 2 \(\tilde{\text{D}}\) Cremetion 3 \(\tilde{\text{U}}\) 4 Donation 5 \(\tilde{\text{O}}\) Other (Specify,	Removel from State	cemetery, ca	position (Name of remetory or other pake Crema		Date 2-9-99		City or Town, State
Balti permit. Departm Importa any inju	21. Signature of Funeral Service Licens			22. Name end Add Rapp Fune	lress of Facility	vices, P.		in the state of th
	23a Part 1 Enter the disease or come	lications that forest the day	th Do not a	933 Gist	Avenue,	Silver S	pring, M	
Physician	23a. Part1. Enter the disease, or comp shock, or heart feilure. List only of	one cause on each line.	iui. Do not e	intel the mode of d	ying, soon es card	nac or respiratory e	arrest,	Approximete Intervel Between Onset and Death
/Medical Examiner	Immediate Cause (Finel disease or condition	Respirato	ry Fai	llure				1 day
E P	resulting in death)	Subdural	11-11-11	sequence of):				6 months
68760, fficate be executed to physician and as the burial-transit Aedical Examinel	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to		equence of):				22 months
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Box eath cert attendin I for use						l ent mu		
P.O. do by the detached by the	Part It. Other significant conditions co	ntributing to death but not re	sulting in the	underlying cause	given in Pert I.		37	tribute to the cause of deati
aw requires to been sign 2 should be							s an autopsy ormed?	24b. Wera autopsy tindings aveilable prior to completion of cause of death?
The late has go and a second						10	Yes 2⊠No	1 ☐ Yes 2 No
yetcien: Thy s certificate director, pag	25. Was case referred to medical axaminer?				26. Place of I	Death (Check only	one)	
Of Vita Physician: this certific ral director.	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 [☐ ER/Outpati	ient 3 DOA	Other: 4 Nursin	Home 5 Res	idence 6 Othe	er (Specify)
VISION OF Attending Phyric death. Sector: After thi by the funeral	27. Menner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time Injury	W	iury at /ork? □ Yes 2 □ No	28d. Describe	how injury occurr	ed
or At ther of Sirect in by	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Special Control of the	nome, farm,	street, fectory, offic	0		(Street end Number own, Stete)	er or Rural Route Number,
Divi	29a. Certifier 1 A Certifying Phy (Check only one)	reician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, dea	ath occurred et the investigation, in my	time, date and pla opinion, deeth or	nce, and due to the occurred et the time	cause(s) and ma , date and place, e	nner es stated. and due to the cause(s)
To the comple	29b. Signature and title of certifier) 0		29c. Lice	nse number		29d. Date signed	(Month, Day, Year)
19	Kovin ()	Callen	mi	17	526		February	8, 1999
	30. Neme end address of person who co Kevin J. Cullen,					ashingto	n, DC 20	0007
State Registrar	31. Dete filed (Month, Pay, Year) FEB 0 8 199		ature	Soon		9		



State of Maryland / Department of Health and Mental Hygiene Q

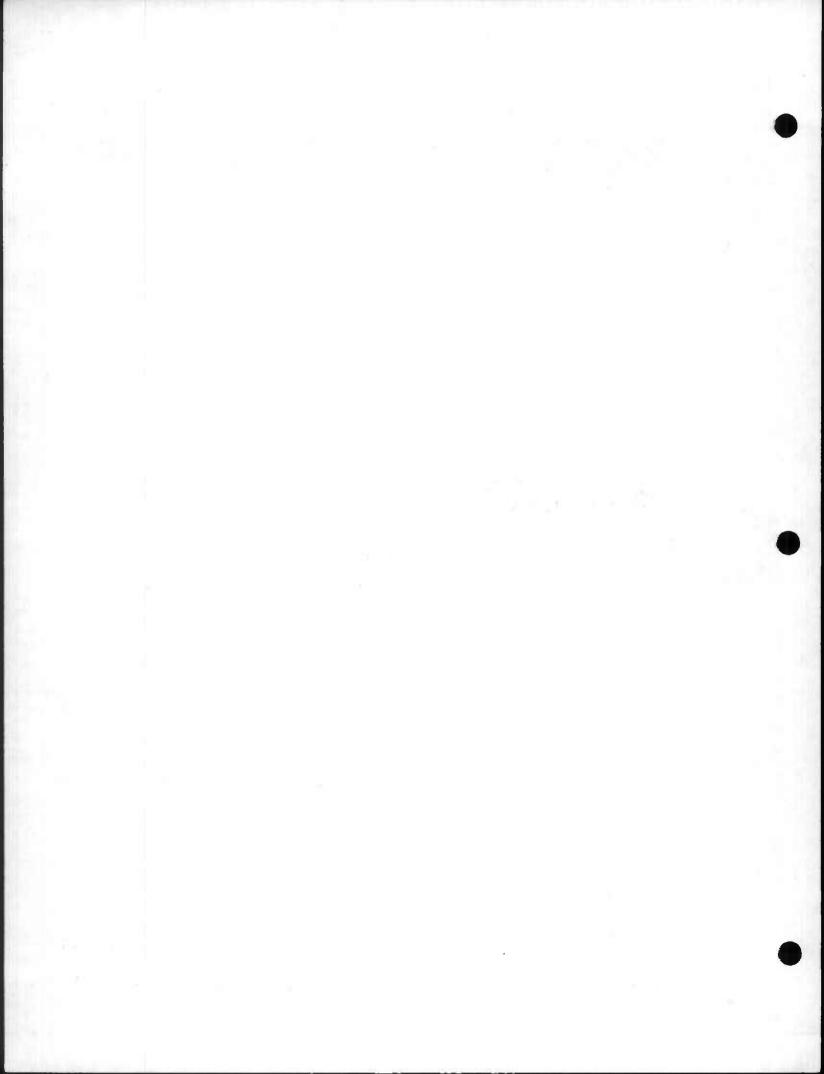
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dev **Physician** John February 6, 1999 9:55 PM Jones /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Shady Grove Adventist Hospital Rockville, MD ROCKVIII

If Under 24 Hrs. 8. Date of Birth
Hours Min. November 4,1937

| RockvIII
| South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Carolina | South Montgomery If Under 1 Year 5. Sociat Security Number 7. Age (In yrs. last birthday) **Funeral** Days XXM 2□ F Months 248-60-2560 61 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. tnside City Limits Gaithersburg Director Maryland Montgomery 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g Citizen of What Country? United States 12326 Quince Valley Drive 20878 of America death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian Bleck, White, etc. filed within 72 hours after 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 Specify: Black 1 ☐ Yes 2 No Specify: á 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuet Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Ktnd of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Tolonii: Pages 1 and 2 should be fits Department of Health and Mental Hy Important: If then 27 is marked oth any injury or other traumatic event once. Be Alex Jones Martha Gary 2 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. tnforment's Name/Relationship (Type, Print) Doretha Jones/ Wife McDonald Circle, Cheraw, South Carolina 29520 20e. Method of Disposition 20c. Location - City or Town, State Cheraw, 20b. Place of Disposition (Neme of Dete cemetery, cremetory or other plece) Rebruary 1 Burial 2 Cremation 3 Removal from State 13, 1999 Montrose Cemetery South Carolina 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Grooms Funeral Home 711 Highway #1, South, Cheraw, South Carolina Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Physician /Medical Immediete Ceuse (Final disease or condition resulting in deeth) Examiner Examiner sel The law requiras that the death certificete be executed -transi Sequentielly list conditions, if eny, teeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury end Due to (or es e consequence of) physician er Box 68760. Physician/Medical thet initiated events resulting in deeth) Last the Due to (or es e consequence of): use as P.O. Part It. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the cause of deeth? the signed by the 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, þ Completed 24b. Were eutopsy findings eveilable prior to 24e. Wes en eutopsy performed? peen completion of cause of death? page 2 s 1 ☐ Yes 2 No certificate 1 ☐ Yes 2 No of Vital To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director; p Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Naturel tniury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of tnjury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 I Homicide Certifying Phyelclen: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Exeminer: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of 29c. License number FEBRUARY, 7, 1999 30. Name end eddress of person who completed ceuse of death (ttem 23a) (Type, Print) EDMONSTON DR, ROCKVILLE, MD. SWAROOF-G. RAO 50, W. 31. Date filed (Month, Day, Year) 32. Registrer's Signature State FEB 10 1999 Registrar



	EMS:	JDY: #23 PART I. 27.	PER MEO G	768 2-24-	99 WR	Certifica	te of	Death	1.0	Date of Dea	Reg. No.	11.	3. Tima of Death
nysician		ecadent's Name <i>(First, Middle,</i> Phyllis M. Jud								Month FEB.	Day 19	Year Q Q	0730 A
'Medical xaminer	_	Facility Name (If not institution, s	iva street and n	umber)				4b. City, Town	n, or Local	tion of Death	4c. County	of Death	
	5.5		. Sex	7. Age (In yrs	to me to inte	oday) If Line	er 1 Year	SANDY		Date of Birt	MONT		
neral ector		579-05-2237	1□ M 2X F	7. Age (III yis		Month			Min.	(Month, Da)	y, Year) B, 1917		aca (Stata or Foraid try) ode Islan
		al Residence of Decedent State 10b. County		10c. C	ity. Town	or Location						1	Od. inside City Limit
induction in terms can be notified at			gomery			Spring							1☐Yes 2☐N
be notified Director		Street and Number	gomer y	50	illuy	-	ip Code				10g. Citizen of W	/het Coun	trv?
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Funeral	11	Marital Status		cedent Evar in U	IS.	13. Was Dec		20860 Hispanic Origin	n? (Specif	v Yes or No	USA 14. Race	e - Amaric	an Indian,
5	11.	1 ☐ Nevar Married 2 ☐ Married	Armed F	orcas? 2 XNo		If Yes, s	ecify Cub	Hispanic Origin pan, Mexican, I	Puerto Rio	can, etc.)	Blac	k, White,	
by		3 □ Widowad 4 □ Divorced	If Yes, G	iiva **		1 ☐ Yes	2 No	Specify:			Specify		
		15. Decedent's			16a. I	Decedent's Us	uel Occu	nation			16b. Kind of Bu		nite
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m C	E	lementary/Secondary (0-12)	College	(1-4or 5+)	-	cretar					Govern	_	00.
	17.	Fether's Name (First, Middle, La	st)					18. Mother's	s Name (F	First, Middle,	Maiden Sumem		
Be G		Charles W. Eddy						Roze1	la M	oore			
7		. Informant's Neme/Reletionship	(Type Print)		10h	Malling Addre	se /Strao				er, City or Town,	State 7in	Code)
													0000)
		Karen Gregory/I	augnter	20b.	Placa of	Disposition (A	ame of			Spring	MD 20 20c. Location -		wn. State
		1 Burlal 2 ☐ Cremation 3	Removal from		cemetery	, crematory o	r other pla	ace)	1	5410	200. Education	Only or To	vivi, otato
		4 Donation 5 Other (Spe		C	edar	Hill_				b 9	Suit1		
DUCE.	21.	Signature of Funeral Servica Lic	ansae	^							aldi Fun		
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	238	a. Part1. Enter the disease, onco shock, or haart failure. List or	mplications that	caused the dea	ith. Do no	ot enter the m	ode of dy	ing, such as ca	ardiac or r	aspiratory a	rrest,		Approximata Interval Between
1													Onset and Death
1		nediate Cause (Final		R	RUNCH.	IAL ASTH	мΔ						
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camine	Sec	quentially list conditions,	b	Due to (or as a co	onsequenca o	f):						
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Ca	thai	use (Disease or Injury i initieted events	C	Dua to (or as a co	onsequence o	0:						
8	rest	ulting in death) Last		· ·									
2			d										
SICI	Part	II. Other significant conditions	contributing to	death but not re	sulting in	the underlying	cause gi	iven in Part I.		23b. Did	tobacco use cor	ntribute to	the cause of gest
										10	Yes 2 No	3 □ Pro	oably 4 Unkno
hys													
by Physician/Medical	-									24a. Was	an autopsy		era autopsy finding
by										perio	ville01	co	mpletion of cause
by										10/	Yas 2□No		Yes 2□ No
by									4.00 - 11 - 11		23		2010
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Be Completed by	25.	Was case referred to medical examinar?	Hospital:	Name of the second	7.50/0.4		Ot Ot	26. Place o				or /Coonid	۵
To Be Completed by	25.		11		ER/Out		DUA	ther: 4 Nurs	ing Home	XXResid	denca 8 Oth		1)
To Be Completed by	25. 27.	examinar? XXYes 2□ No Menner of Deeth 1 ☑Netural 5 ☑ Pending	28e. Date (Mo	Inpatient 2E e of Injury with, Day Year)	28b. Ti	me of jury	28c. Inju	ther: 4 Nurs	ing Home	XXResid			y)
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State Registrar

31. Date filed (Manth, Day, Year)

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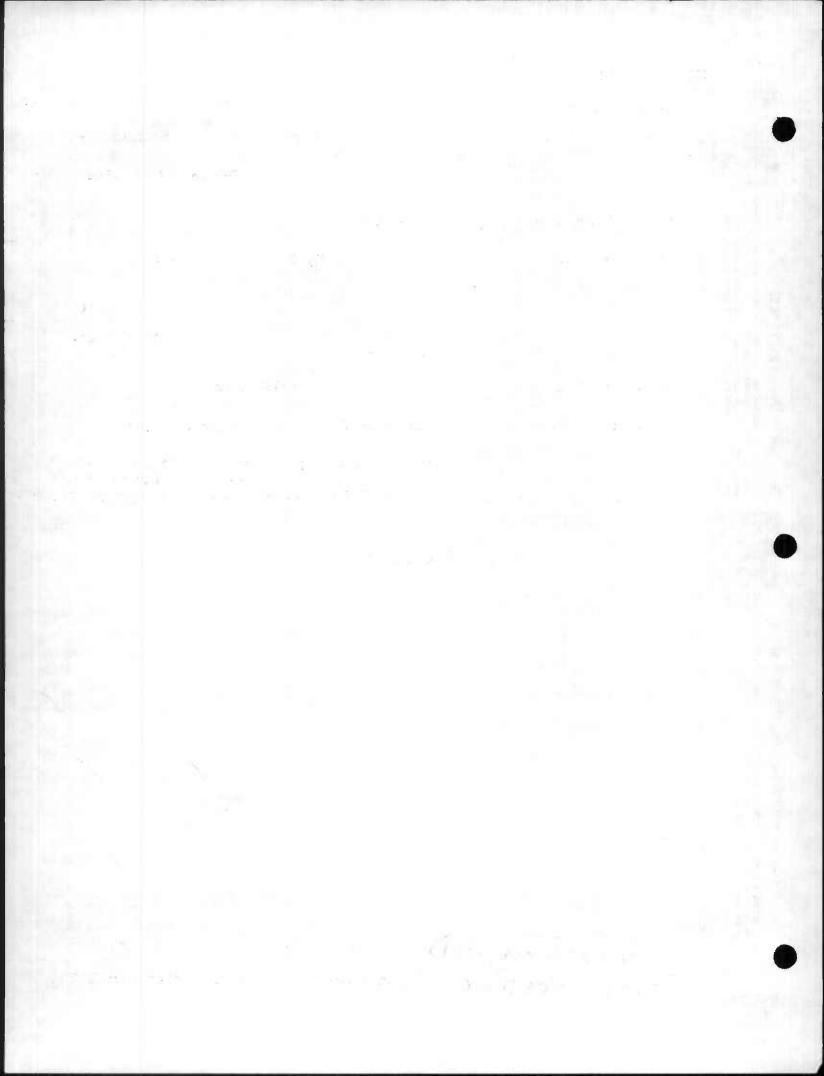
cause of deeth (Item 23a) (Type, Print)

Lucc 111 Penn Street, Baltimore, Maryland 21201

O.C.M.E

FEB.

6, 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					arylaria	Certific		Death		Reg. No.	3 0542	9
	Physic	ian	1. Decedent's Neme (First, Middle, s Mildred Larue Ke						2. Dete of De Month	Day	Yeer	Deeth
	/Medi		4e. Fecility Neme (If not institution,					4b. City, Town, or Lo	Februar	-	1999 2110	
	Examir Funeral Director	ner	The Kent & Queen 5. Sociel Security Number 6 195–32–8004	Anne's Hos		it birthdey) If U	nder 1 Yeer	hestertow		Kent	9. Birthpiece (State of Country) Pennsylvania	or Foreign
	and w		Usual Residenca of Decedent 10a. State 10b. County		10c City T	Town or Location						10 - 1 fee 10 -
	Maryti f sho	ō	Maryland Kent			stertow	2				10d. Inside Ci	
	r 28a	rec	10e. Street end Number		OHO		. Zip Code			10g. Citizen of	Whet Country?	
	th with	ai D	21203 Carolina Av	enue			21620			USA		
020	ours efter dea al', or Items Examiner m	by Funeral Director	11. Maritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 2 N If Yes, Give Yeer or Detes:			ecedent of H specify Cube s No	lispenic Origin? (Spe en, Mexican, Puerto Specify:	cify Yes or No Rican, etc.)	- 14. Rac Ble Specif	ea - American Indien, ck, White, etc. y: White	
21215-0020	permit. Pages 1 end 2 should be filled within 72 hours efter death with the Maryland Depertment of Heelth end Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's (Specify only highest g Elementery/Secondary (0-12) 1 2	Education trade completed) College (1-4or 5	5+)	16e. Decedent's I (Give kind or life. Do No Teacher	Jsual Occup f work done oT use retired	etion during most of worki d)	ng	16b. Kind of B	usiness/Industry	
Maryland	be file tal Hy d othe	Be	17. Fether's Neme (First, Middle, Le.	30)				18. Mother's Neme				
Z	Men Men Marke Marke	To	Elija Walter Fox					Susanna				
	end 2 st eelth end n 27 is m		19a. Informent's Neme/Reletionship Susan L. Nichols	(Type, Print)				end Number or Rure			Stete, Zip Code)	
re,	f Heel f Heel tem 2 other		20a. Method of Disposition		20b. Plac	e of Disposition (letery, crematory	Neme of	, Willow	Dete Dete		City or Town, Stete	
E O	Pages nent of I int: if ite		1 ☐ Burlel 2 ☐ Cremation 3 4 ☐ Donetion 5 ☐ Other (Spec					enter, LIC	2/12/99	Stevensv	ille. MD	
Baltimore,	Depentral imports any inju		21. Signeture of Funeral Service Lic	ansee A-	10093	Fellow	e end Addre	ss of Fecility Cenbein & Ne ad, Chestert	wnam Fun	eral Home		
>	Physician /Medical Examiner	ner	23a. Part1. Entay he disease of co shock, or shart failure. List on Immediate Ceuse (Final disease or condition resulting in deeth)	. Enta	o coli 4		ndan	g, such es cardiac o			Intervet Ben Onset and to	Deeth
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ecord	law requirens been si	Completed	Renal Fac	lux					24e. Wes perfo	en eutopsy rmed?	24b. Were eutopsy fi eveilable prior to completion of co of deeth?	0
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Vital	ysicien: The s certificate director, pag	o Be	25. Was case referred to medical exeminer?	Hospitel:			DOA Othe	26. Plece of Deeth				
ō	ding Phys th. After this funeral di	-	1 ☐ Yes 2 ☐ No 27. Menner of Deeth	Hospitel: Inpatier	y 28	Outpetient 3 D	28c. Injun	4 □ Nursing Hor		lenca 6 □Oth		
0	eth. r: Atte	atio	1 ☑Naturel 5 ☐ Pending 2 ☐ Accident Investigati	(Month, Dey	Year)	Injury M		Yes 2 □ No				
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			30. Name end address of person who	completed cause of de		le) (Type, Print)	h 5 4 - 1	La Aso	00. A	- ton-	Md 266:	20
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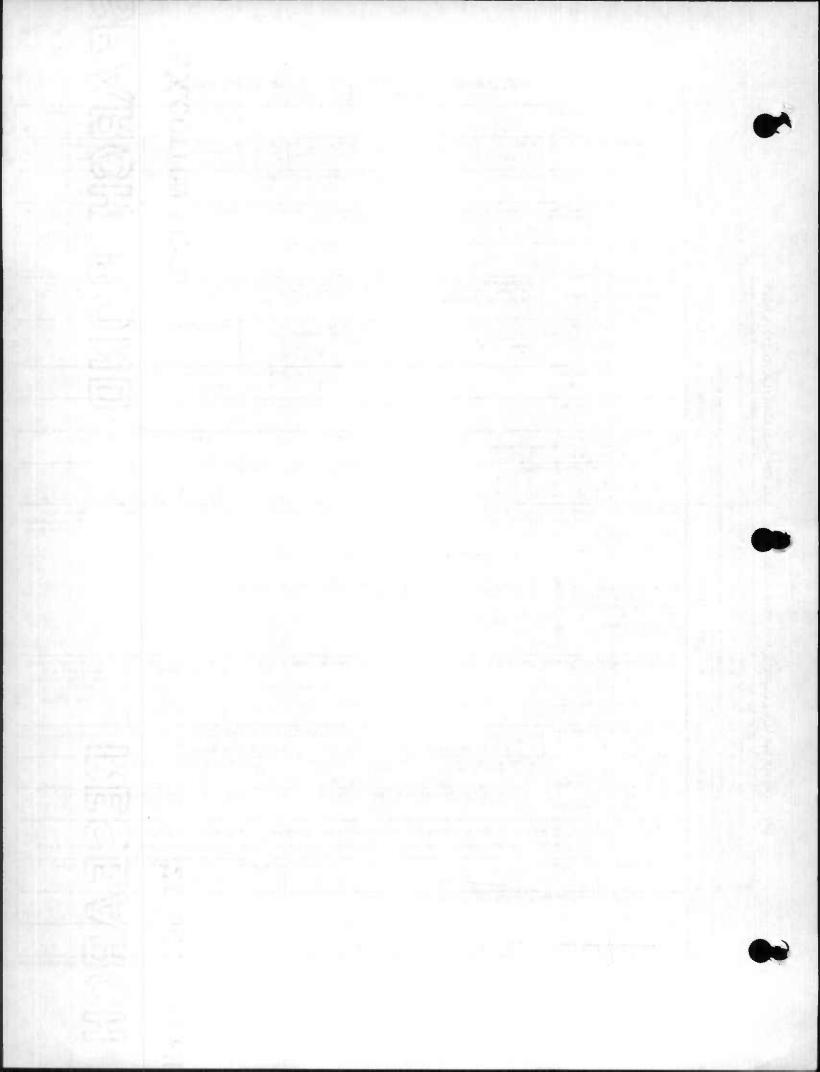
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ITENDING PHYSICIAN: The law requires that the death certificate be executed within a monus after death. Page 6 may be retained by the hospit	TOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	
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	1. DECEDENT'S NAME (First, Middle, La	est)	Cl	-11111	IOAIL	OF DE	4111	REG.	Н	We an	3. TIME OF DEATH
	John Thomas	Kent,	Sr.					Februar	y I	1999	5:50AM
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les		IF UNDER 1	YEAR IF UNI	DER 24 HRS.	7. DATE OF BIRTH (Month, Day, You	r)	8. BIRTN Countr	IPLACE (State or Foreigny)
	455-13-8757	1 🔀 M 2 🗆 F	41	YAS.				Jan. 24			Texas
œ	9e. FACILITY NAME (If not institution, gi				9b. CITY, T	TOWN OR LOC		EATH		UNTY OF D	EATH
Ō.	10182 Winston					Frede	rick			rrede	erick
DIRECTOR	10e. STATE 10b. COU	UNTY		10c. CI	Y, TOWH OR	LOCATION			77		10d. INSIDE CITY
	Maryland	Frederick				Frede	rick				1 YES 2 X NO
Z Z	10e. STREET AND NUMBER					101. ZIP C			10g. Cl	TIZEN OF W	WHAT COUNTRY?
FUNERAL	10182 Winston D						21701			1	.S.A.
BY FU	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS OECEDEN FORCES? 1 IF YES, GIVE V	IT EVER IN U.S. AR YES 2 1	IMED NO	If 3		iban, Maxici	NIC ORIGIN? (Specifin, Puerto Ricen, etc y:		14. RACE Black Speci	E — American Indian, k, White, etc. My: White
ED	15. DECEDENT'S	EDUCATION	16e. DE	CEDENT	USUAL OCC	UPATION		16b. KIND OF	BUSINESS/IN	IDUSTRY	
	(Specify only highest g	College (1-4 or 5	+) #fe.	. Do NOT u	se retired.)	ring most of wo					
COMPLET	12			serv	ice te	echnic			pest		rol
ပ္ပ	17. FATHER'S NAME (First, Middle, Leet) Waynas Kent					16. M		ME (First, Middle, Me			
BH	19a. INFORMANT'S NAME (Type/Print)		140		· ADDRESS (veree Ha			
2	Tracy B. Kent/	wife				ton Dr		Aoure Number, City of Frederic			1
	20a. METHOD OF DISPOSITION	WIIC			OF DISPOSIT		•		LOCATION -		
	1 X Buriel 2 Cremetion 3 X f 4 Donation 6 Other (Specify)	Removal from State	cemetery, cre	metory or	ther place!	emeter	* 17		lancha		
	a Time	(1)	. 701/2	.)				Hartz			
	IMMEDIATE CAUSE (Final disease or condition	pr complications the	nt caused the deuse on auch line	eath. Do	118	302 Li	berty	Rd.	Libert	ytowi	Approximat
CERTIFICATION	ahock, or heart failu IMMEDIATE CAUSE (Final	a	(OR AS A CONSECUTION OF AS	QUENCE O	118 not anter the	302 Li	berty	Rd.	Libert	ytowi	Approximate Interval Bets
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P 1564 0 32. REGISTRAR'S SIGNATURE

FEB 0 5 1999

DHMH-16 Rev 1/89



State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 3. Time of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) **Physician** 16:51 MARTAN ALVINA KELLY 4 1999 FEB. /Medical CARROLL COUNTY GENERAL HOSPITAL

| WESTMINSTER | COUNTY GENERAL HOSPITAL | WESTMINSTER | COUNTY GENERAL HOSPITAL | WESTMINSTER | COUNTY GENERAL HOSPITAL | WESTMINSTER | COUNTY GENERAL HOSPITAL | WESTMINSTER | COUNTY GENERAL HOSPITAL | WESTMINSTER | COUNTY GENERAL HOSPITAL | WESTMINSTER | COUNTY GENERAL HOSPITAL | WESTMINSTER | COUNTY GENERAL HOSPITAL | WESTMINSTER | COUNTY GENERAL HOSPITAL | WESTMINSTER | COUNTY GENERAL HOSPITAL | WESTMINSTER | COUNTY GENERAL HOSPITAL | WESTMINSTER | COUNTY GENERAL HOSPITAL | WESTMINSTER | COUNTY GENERAL HOSPITAL | WESTMINSTER | COUNTY GENERAL HOSPITAL | WESTMINSTER | COUNTY GENERAL HOSPITAL | WESTMINSTER | COUNTY GENERAL HOSPITAL | WESTMINSTER | COUNTY GENERAL HOSPITAL | WESTMINSTER | COUNTY GENERAL HOSPITAL | WESTMINSTER | COUNTY GENERAL HOSPITAL | WESTMINSTER | COUNTY GENERAL HOSPITAL | WESTMINSTER | COUNTY GENERAL HOSPITAL | WESTMINSTER | COUNTY GENERAL HOSPITAL | WESTMINSTER | COUNTY GENERAL HOSPITAL | WESTMINSTER | COUNTY GENERAL HOSPITAL | WESTMINSTER | COUNTY GENERAL HOSPITAL HOSPI 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Name (If not Institution, give street end number) Examiner CARROLL 5. Sociel Security Number **Funeral** 73 6/2/1925 Director 220-14-2296 MARYLAND Usuel Residence of Decedent with the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show ancuffed at 1 ☐ Yes 2 No Directo CARROLL MD. WESTMINSTER 10g. Citizan of Whet Country? 10e. Street end Number 10f. Zip Code r than "naturel", or items 23s or the Medical Examiner must be 911 BEAR BRANCH RD. 21157 USA. permit. Peges 1 and 2 should be filed within 72 hours effer death w Department of Health and Mental Hygiene. Important: If fem 27 ie marked other than "natural injury or other traumation." Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 14. Reca - American Indien. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status Black, White, etc. 1 Never Married 2 Married 1 Yas 2 No Specify: þ 3 ☐ Widowed 4 ☑ Divorced WHITE Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamantary/Sacondary (0-12) Collage (1-4or 5+) SEAMSTRESS CLEANERS 6 18. Mother's Neme (First, Middle, Melden Sumeme) 17. Fether's Neme (First, Middle, Last) MARION MARSHALL JOSPHINE IRELAND 19a. Informant's Neme/Raletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Coda) -DAUGHTER 911 BEAR BRANCH RD., WESTMINSTER, MD. 21157
20b. Place of Disposition (Name of Dete 20c. Location - City or Town, State MARIAN F. EUSINI 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 1 ☐ Burial 2 💆 Cremetion 3 ☐ Removel from State METRO CREMATORY 2/5/99 4 ☐ Donetion 5 ☐ Othar (Specify) BALTIMORE, MD. 21. Signeture of Funerel Service Licensee 22, Name end Address of Fecility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Daath Physician Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical Cerebrovascular Accident Examiner Examiner gangrene of physician end the buriel-transit the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Causa (Disaesa or injury that initieted events resulting in death) Lest P.O. Box 68760. Physician/Medical Due to (or es e consequence of) 80 USB signed by the a 23b. Did tobecco use contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed certificate has b 1 Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was casa rafarred to madical exeminar? Be 26. Placa of Daeth (Check only one) Hospitel: 1 Manpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) funeral 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: After 1 Matural 5 Pending death. 1 Yes 2 No investigation 2 Accident aftar deat Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 6 4 Homicida To the Hospital or A within 24 hours aftar To the Funeral Directomplately filled in by 29a, Cartifiar 1 Certifying Physician: To tha bast of my knowledga, daath occurrad at tha tima, data and place, end due to tha causa(s) and mannar as steted. edicai (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) end menner stated.

State Registrar

31. Dete filed (Month, Day, Year)

FEB 0 5 1999

29b. Signature and title of cartifier

Hospital, 200 memorial Avenue. Westminster, 32. Registrer's Signeture

m. D

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) LISA KTM, MP. at Carroll County

29c. License number

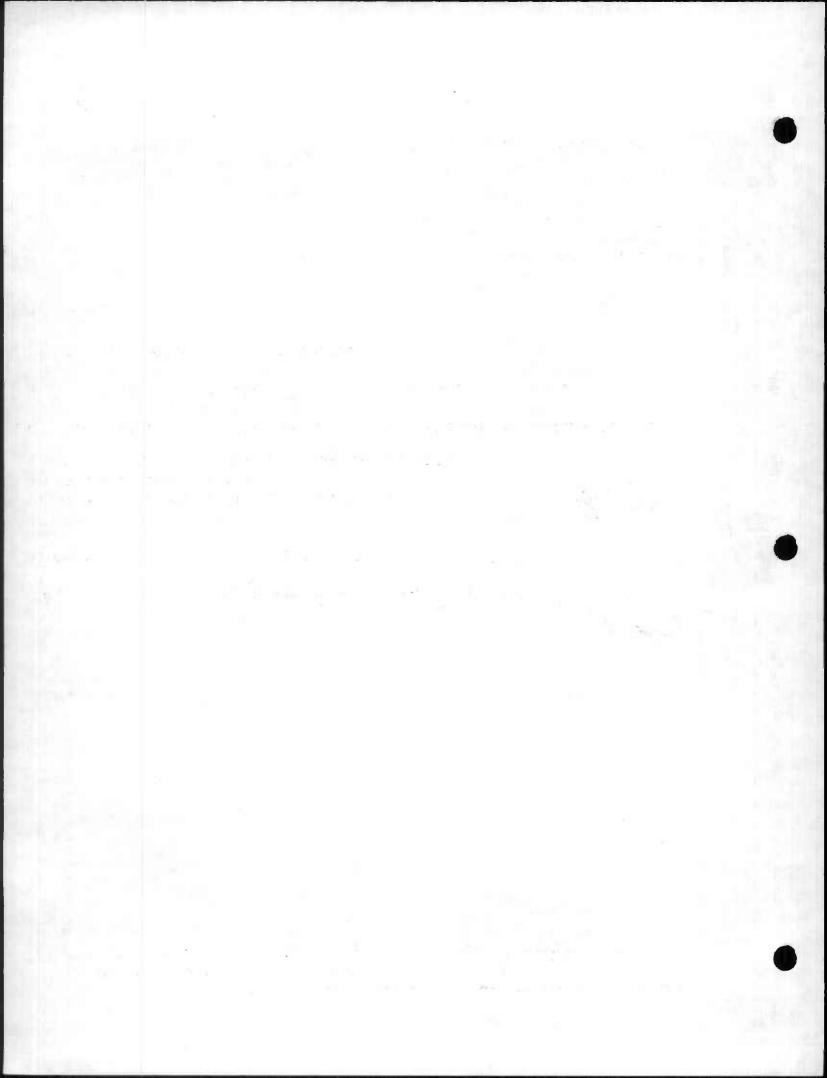
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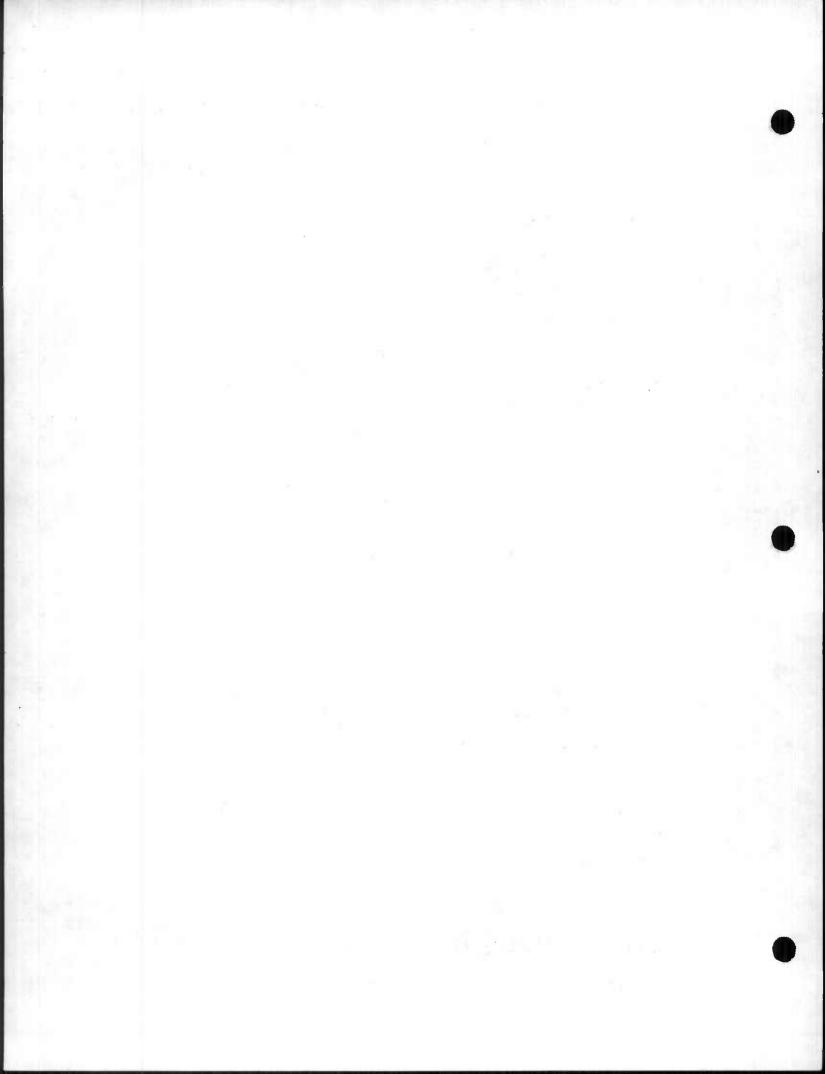
29d. Dete signed (Month, Dey, Year)

February, 4, 1999

General



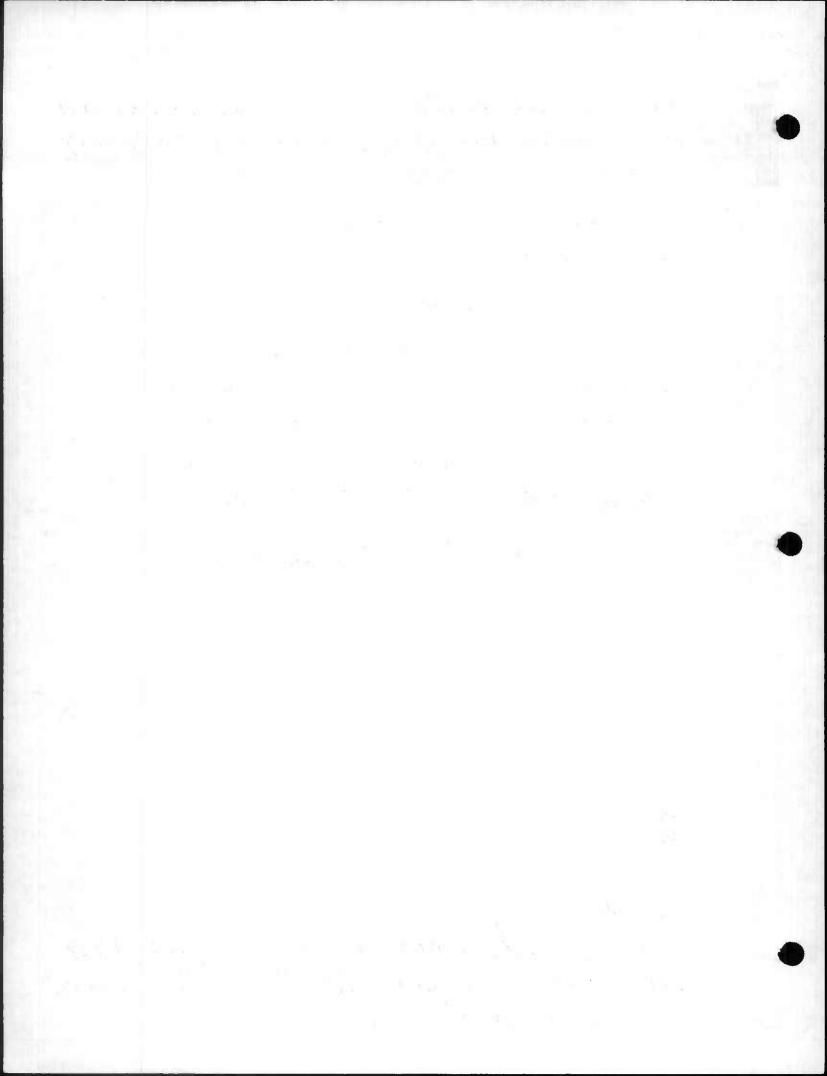
## Facility Name (if not institution, your stream and number) 10.0009 Lexington Street 10.000	_	Decedent's Name (First, Middle, Last	State of Mary	•	ertificate of			Reg. No. 99	05432	
PAIL 1.1	Physician						Month	Day		
106.09 Lexington Street Secondary Number Secon				J.	Kel					
Social Security Numbers 6. Dees 100 Miles 7. April 10 m/m and printing 100 Miles	Examiner				4 4	4b. City, Town, or	Location of Deet	4c. County of	Death	
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The Store 10c. Chry Town to Location 10c. Chry Town or Location 10c.	Emaral Director	225-10-5577 1☑M 2□F 87 Yrs. Months Days Hours					8. Date of Bir (Month, De April 2	th (Year) 1911	9. Birthplece (State or Foreign Country) Illinois	
106.09 Lexington Street 106.09 Lexington Street 10.00									10d. Inside City Limits	
106.09 Lexington Street 106.09 Lexington Street 10.00	69 69	Maryland Montgom	ery	Censingt	on				1 X Yes 2 □ No	
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232	o de	Harry B. Keller				Daisy M. McClure				
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232	77 H	Eleanor M. Keller	(wife)	1060	9 Lexingt	on Stree	t, Kensi	ington, M	aryland 2089	
Secure 1933 Cast Avenue Silver Spring MD 20910	E &		20	b. Place of Disp	osition (Neme of	1	Dete	20c. Location - C	ity or Town, Slate	
232	5 = 8		Hemoval from Stete				2 10 00	2 1	1 1	
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Cerebrovascular Insufficiency Cerebrovascular Insufficiency	his certificate has been signed adjrector, page 2 should be d	Congestive Heart Failure, Chronic Renal Failure,					1 Yee 2 No 3 Probably 4 Unknow			
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27. Mennar of Deeth 1 Natural 2 Accident 3 Suicide 4 Homicida 28e. Place of Injury - At home, farm, street, fectory, office 29e. Certifier (Check only one) 29e. Certifier (Check only one) 29e. Signature and title of certifier 29e. Signature and title of certifier 29e. Signature and address of person who complete of charge of death (Item 23a) (Type, Print) Martin Shargel, M. D., 720 Farragut Avenue, Kensington, Maryland 20895 31. Date filled (Month, Dey, Year) 32. Registrar's Signature 32. Registrar's Signature 28e. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred Work? 1 Yes 2 No 28d. Location (Street end Number or Rural Route Number, City or Town, Stata) 28d. Describe how injury occurred Work? 1 Yes 2 No 28d. Location (Street end Number or Rural Route Number, City or Town, Stata) 28d. Describe how injury occurred Work? 1 Yes 2 No 28d. Location (Street end Number or Rural Route Number, City or Town, Stata) 28d. Describe how injury occurred Work? 1 Yes 2 No 28d. Location (Street end Number or Rural Route Number, City or Town, Stata) 28d. Describe how injury occurred Work? 1 Yes 2 No 28d. Location (Street end Number or Rural Route Number, City or Town, Stata) 28d. Describe how injury occurred Work? 1 Yes 2 No 28d. Location (Street end Number or Rural Route Number, City or Town, Stata) 28d. Describe how injury occurred Work? 1 Yes 2 No 28d. Describe how injury occurred Work? 1 Yes 2 No 28d. Describe how injury occurred Work? 1 Yes 2 No 28d. Describe how injury occurred Work? 1 Yes 2 No 28d. Describe how injury occurred Work? 1 Yes 2 No 28d. Describe how injury occurred Work? 1 Yes 2 No 28d. Describe how injury occurred Work? 1 Yes 2 No 28d. Describe how injury occurred Work? 1 Yes 2 No 28d. Describe how injury occurred Work? 1 Yes 2 No 28d. Describe how injury occurred Work? 1 Yes 2 No 28d. Describe how injury occurred Work? 1 Yes 2 No 28d. Describe how injury occurred Work? 1 Yes 2 No 28d. De		examinar?	Hospital:	2 □ FR/Outnatio	77					
30. Name and address of person who completed chuse of death (Item 23a) (Type, Print) Martin Shargel, M.D., 3720 Farragut Avenue, Kensington, Maryland 20895		27. Mennar of Deeth 1 ☑Natural 5 ☐ Pending	28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Injury M 1 Yes 2 No			7				
30. Name and address of person who completed chuse of death (Item 23a) (Type, Print) Martin Shargel, M.D., 3720 Farragut Avenue, Kensington, Maryland 20895 31. Date filed (Meeth-Deva Year) 32. Recistrar's Signature		dataminad	289. Piece of injury - At nome, farm, street, fectory, onice							
30. Name and address of person who complete rouse of death (Item 23a) (Type, Print) Martin Shargel, M.D., 720 Farragut Avenue, Kensington, Maryland 20895		(Check only 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
30. Name and address of person who completes these of death (Item 23a) (Type, Print) Martin Shargel, M.D., 720 Farragut Avenue, Kensington, Maryland 20895	M M	29b. Signature and title of certifier	,		29c. Licens	se number		29d. Date signed	(Month, Dey, Year)	
Martin Shargel, M.D., 3720 Farragut Avenue, Kensington, Maryland 20895		Martin Concept 19						February	9, 1999	
State 31. Date filed (Hope Dex Year) 32. Registrar's Signature		Martin Shargel, M.D., 3720 Farragut Avenue, Kensington, Maryland 20895								
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State of Maryland / Department of Health and Mental Hygiene

					Certif	icate of	Death		Reg. No.	J U	543	3
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Exami	ner	4e. Fecility Nama (If not institution 9500 Car		ve			4b. City, Town, of	Forms	Mon	y of Daath	nery	
Funeral Director		5. Social Security Number 214–36–3689	6. Sex 7. A 1 AM 2 □ F	lga (In yrs. last bir 59		Undar 1 Yaa onths Day		rs. 8. Deta of Bir (Month, De March	th 19, Year) 9, 1939	9. Birthp Court Wyom	placa (State or I	Foreign
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eryla shor	_									1	10d. Insida City 1 ☐ Yes 2	
h the Merylan r 28a-f show	ecto		gomery	Silve	er Sp							: 63140
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Maryladd 2 should the ond Men Tis marke traumatic		19a. Informant's Name/Ralationsh	ip (Type, Print)	19b	. Mailing A	ddress (Stree	et and Number or	Rural Routa Numb	er, City or Town	, Stata, Zip	Coda)	
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Geth certificate be executed deeth certificate be executed e ettending physician and dor tose es the bunal-transit	VMedical Examiner	Sequantially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last										
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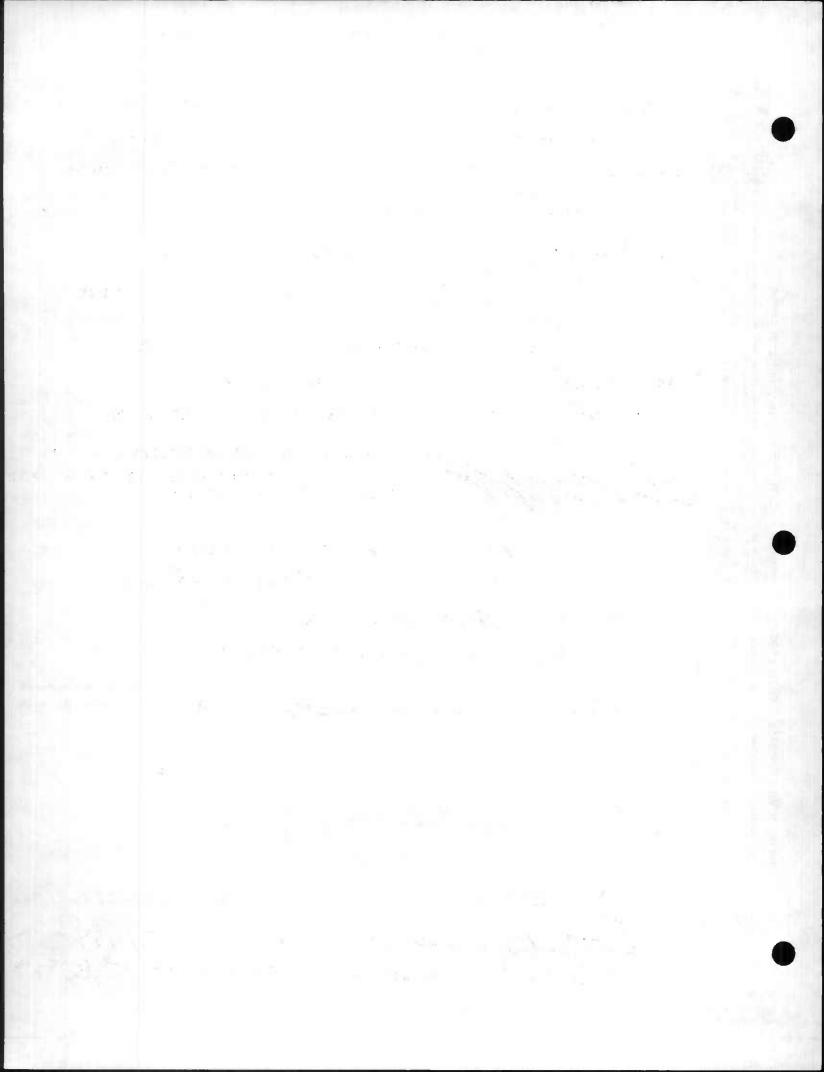
State of Maryland / Department of Health and Mental Hygiene Q Q 51, 31,

				Cer	tificate of	Death		leg. No.	00	7,04
Physician	Decedent's Name (First, Middle,	Last)					2. Dete of Dee Month	th Dey	Yeer	3. Time of Death
/Medical	DONALD MARION KE	NDALL					FEBRUAR	Y 8, 19	99	1:44 PM
* Examiner	4a Facility Neme (If not institution,	give street end numl	ber)			4b. City, Town, or I	Location of Deeth	4c. County	of Deeth	
	MONTGOMERY GENER	AL HOSPIT	TAL			OLNEY			TGOME	ERY
Funeral Director	5. Sociel Security Number 511-22-0204 Usuel Residence of Decedent	5. Sex 7 1 M 2 □ F	70	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Dey AUGUST	, Year) 5, 1928	Coun	lece (State or Foreign try) NSAS
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the l	10e. Street end Number				10f. Zlp Code			IOg. Citizen of V	Vhet Coun	itry?
with with ID	1617 COLESBERG S	ST.			2090	15		USA		
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Mental Me	JESSE CLYDE KENI	DALL				LELIA SO	PHIA CUR	TIS		
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Physician /Medical Examiner	shock, or heert feilure. List or Immediate Causa (Final disease or condition resulting in death)			Co/	Lovison uence of):	y Oc Str	ecu,	1 an	2	tritervel Between Onset end Death
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To the Hospital or Attending Phwithin 24 hours after deeth. To the Funeral Director: After thi completely filled in by the funeral completely filled in by the funeral Medical Certification;	3 Suicide 6 Could no determin	ed 256. Place 0	of Injury - At hor g, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (S City or Tow		per or Rura	al Route Number,
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within To the comp	29b. Signature and title of certifier	and it	Ros	REPER	29c. Licen	G877		29d. Date signe	d (Month,	Day, Year)

of deeth (Item 23a) (Type, Print)

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State Registrar



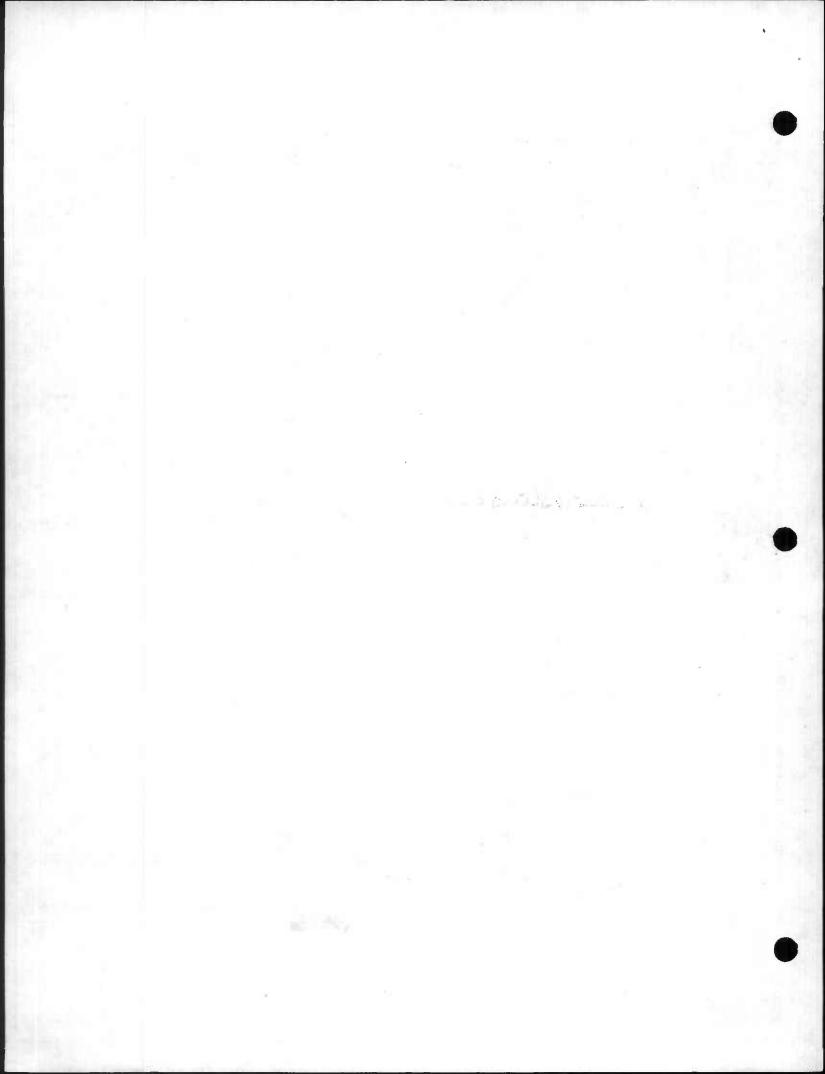
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Terry Kershaw February 3, 1999 8:30 A.M. /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery County 8. Date of Birth (Month, Day, Year)
July 22, 1959
South Carolina If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours 1X M 2□ F 248-29-5798 39 Director Usual Residence of Decedent District 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Columbia None Washington, D.C. 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? à United States 3733 D Street, S.E. Berra 23s 20020 Funeral of America Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, Whita, etc. hours after 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 'natural', or Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Black. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Collega (1-4or 5+) Payroll Clerk Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be peami. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked of any Injury or other traumatic eve Perry Kershaw Ednola Goode 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Joanne Spears/ Sister 303 McClure Street, Union, South Carolina 29379 20e. Method of Disposition 20b. Plece of Disposition (Name of 20c. Location - City or Town, Stete December, cremetory or other piece)
Bethel Baptist
Church Cemetery Feb. 10 Jonesville, 1 ABurlel 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 1999 South Carolina 21. Signel of Funerel Service Licensee 22. Name and Address of Fecility Union Community Funeral Home aus 219 West Main Street, Union South Carolina 29379 Ca 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediete Cause (Final disease or condition rasulting in deeth) Examiner Examiner SEPS15 Sequentially list conditions, if any, laeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Dua to (or es a consequence of): 105 P.O. Box 68760, Physician/Medical signed by the at 5 be detached for Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobaccourse contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 No þ Records. The law requires 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 26 No 1 Yas 2 No 1 Yes of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 20 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Medicai Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After Division 5 Pending investigation 1 Neturel s after death. 1 Yes 2 No 2 Accident MA 6 Could not be datermined 3 Suicide 28e. Piece of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 4 Homicide WA 24 hours a Hospital 29e. Certifian ritifying Physician: To the best of my knowledga, death occurred at the tima, date and place, end due to the cause(s) and manner es stated. completely (Check only one) dicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner steted. To the To the To the F 290. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 7350

of person who completed causa of deeth (Item 23a) (Type, Print)

FEB 10

VAN OUSFEN



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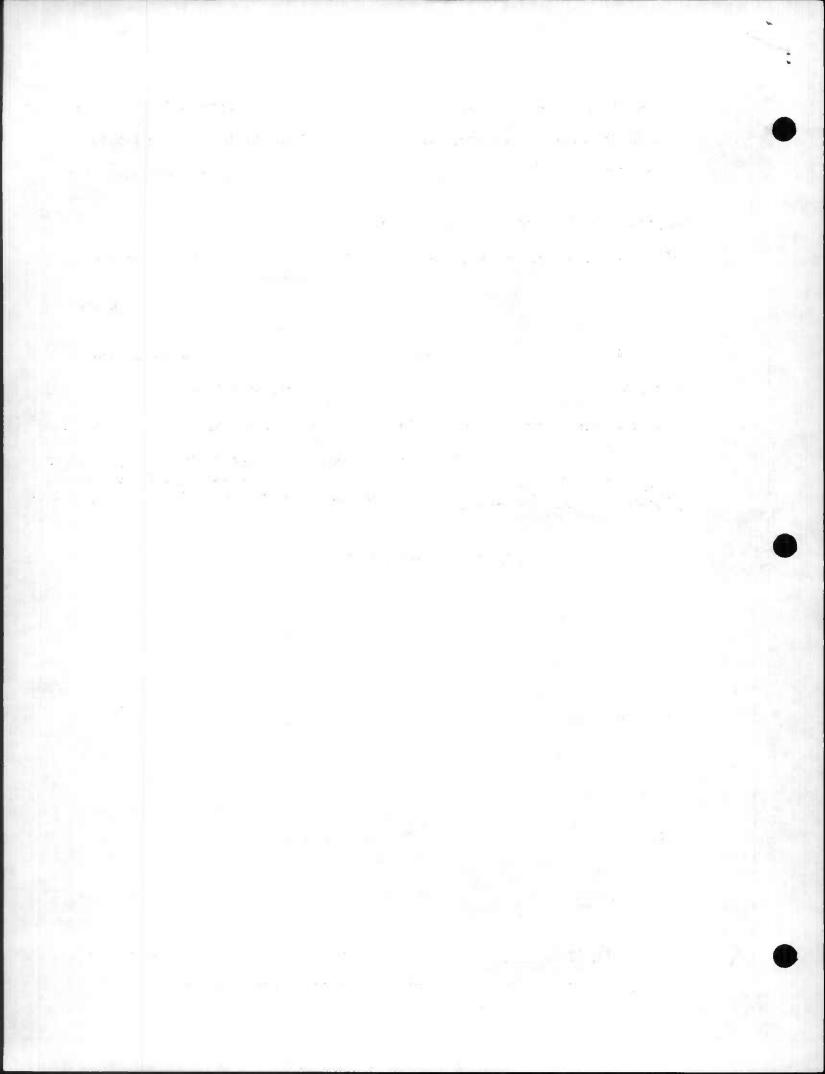
State of Maryland / Department of Health and Mental Hygiene 0 0 Certificate of Death

100		1. Decedant's Nam	na (First, Middla, La	ist)					2. Data of De			3. Tima of Deeth	
Physi /Med				Jennie	Bern	nice Y	oung Kin	ıg	Feb.	8 Day	999	10:35 P.M	
Exam		4a. Facility Nema ((If not institution, giv	a street and number)				4b. City, Town, or	Location of Daar	h 4c. County	of Death		
		Manor Ca	re Nursin	ng Home			20	Chevy Ch	ase	Montg	omer	У	
Funera Directo		5. Social Sacurity N 578-30-0	732	Sex 7. Ag 1□ M 25xF 83	ga (In yrs. le	est birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bi (Month, Di Sept.	th ay, Yaar) 25, 1915	9. Birthp Cour Illi	place (Stata or Foraign ntry) nois	
bue *		Usual Rasidence o	10b. County		10c. City	, Town or Lo	ocation				Π,	I0d. Insida City Limits	
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ath w	<u>a</u>		hedral Av	venue, N.W.			20016			U.S.A.			
I and 2 should be filed within 72 hours efter death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural; or items 23s or 28s-f show rother traumatic event, the Medical Evantiner must be notified at	by Funeral	11. Marital Status 1 ☐ Navar Marr 3 ☐ Widowed	ried 2X Married	12. Was Decedant Armed Forcas? 1 Yas 2 XI If Yas, Giva Yeer or Datas:			Was Decedant of If Yes, specify Cui 1□ Yas 2∑ No	Hispanic Origin? (S ban, Maxican, Puar Specify:	Specify Yas or No to Rican, atc.)	Bla	ca - Amaric ck, Whita, y: Wh:		
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nd 2 should be file ith end Mental Hy 27 is marked other traumatic event.	-	19a. informant's N. James L.	eme/Relationship (Type, Print) Husband	2 0						er, City or Town, Stata, Zip Code)		
emit. Pages 1 er Depertment of Hea mportant: if Item 2 iny injury or other			•	Ramoval from Stata	ce	matary, crai	osition (Nama of matory or other pla ek Cemete		Data 2/12/99	20c. Location -	- V		
permit. Page Depertment of Important: If any injury or		21. Signature of Fu	unerel Sarvica Licer	1960		Ĵ	2. Nama and Addr Oseph Gav	ass of Facility Vier's So	ns, Inc	. 5130 W		nsin Avenue	
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Physician /Medical Examine		Immediata Causa disaasa or conditio		Pulmonary	Edem	a						Onsat and Death 12 hours	
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requir	Completed by	Dementia							24a. Wes	an autopsy ormad?	av	ara autopsy findings eilable prior to mplation of causa daath?	
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To the comp	W	29b. Signatura and	titla of certifier	n n fin.	hour	MD	29c. Licen D 510	se number		29d. Date signe Februa			
20		30. Name and eddr	ass of person who	complated cause of determine #1045	aeth (Itam :	23a) (Type,	Print) E11e	n Pinhol	t, M.D.	Februa	ry 9,	, 1999	

State Registrar 31. Date filad (Month Day, Year) FEB 1 2 1999

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			State of Ma			ificate				Reg. No.	110	1401
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/Medical	Kei		gene Kin	g				0: 7	Februa	-		3:45 P.M
Examiner		New Hampsh		- 4	304			c. City, Town, or			ty of Death	
	5. Social Securit			-	ast birthday)	If Undar 1		Silver S			gomer	7
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deeth with the Marylend rms 23s or 28s-f show rmat be notified at	10e. Street and					10f. Zip Co	ode			10g. Citizen of	What Cour	ntry?
s 23	10100 N	lew Hampshi	re Aveneu			2090:	_	spanic Orlgin? (S		United	State	
or its		s arried 2 Married d 4 Divorced	Armad Forcas? 1 Yes 2 N If Yes, Give Yaar or Dates:		lf '	Yes, specify	Cuba	Specify:	o Rican, etc.)		ack, White, ify:	
n 72 ho natur edical	(S) Elementery/S	15. Decedent's Ed pecify only highest grade econdary (0-12)	de completed) College (1-4or 5	,	life. DO	nd of work of NOT use	done d	uring most of wo	rking	16b. Kind of	Business/In	dustry
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ould be fill Mental Herked off	Harvey (. King						Gertrud	e Belin	da King		
2 shou and M is mar		Name/Relationship (7	ype, Print)		19b. Malling	Address (S	Street a	nd Number or Ru				
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, its MBRB.	20a. Mathod of I	Preston Ki		20b. Pla	ace of Disposi metery, crema	tion (Name atory or othe	of er place	a)	Date	20c. Location	- City or To	
mit. Pages 1 ar partment of Hea portant: if Item. y Injury or other	-	n 5 ☐ Other (Specify	*	Ft.	Lincol					Brentwo		
permi Depari Impo any ir	21. Signaturgo	Funeral Service Licen	1							naldi Fu Silver		Home 20904
Physician /Medical	Shock, or h	neart failure. List only o	plications that caused one cause on each lin	the delitie	Do not enter	the mode of	of dying	g, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
Examiner	disease or cond rasulting in daar	ition	a		Infar							1 Day
ةِ كَنْ سَالِهِ الْمُ				Due to (or	es a consequ	ence or):						
ceta be executed physician end s the buriel-transit	Sequentially list	conditions,	b	Due to (or	as a consequ	ence of):						
iceta be exacul physician end s the buriel-tran		ndarlying or injury	c									
40 00 00	resulting in deat	ents	d	Due to (or	as a conseque	ence of):				4	1	
daath certifi e attanding od for use as	Dort II Other ele	milioant conditions of	estributing to death by	t not room	ting in the une	todulas sau	eo obio	on in Bort I	23h Di	tobacco use o	ontribute t	o the cause of death?
d by the	Hypert	ension	ontributing to death bu	it not resu	iting in the unc	enying cau	se give	n in Parti.		Yes 2 No		bably 4 Unknown
The law requires atta has been sign, page 2 should be		2/1/2	144						24a. Wa	s an autopsy tormed?	av cc	Vere autopsy findings vallable prior to ompletion of cause death?
The law requires that has been signed page 2 should be Completed by									10	Yes 2 No	1	☐ Yes 2☐ No
Physician: The this cartificate ral director, page Co	25. Wes case re examiner?	ferred to medical	11				100	26. Plece of De	ath (Check only	one)		
Physician: this cartific ral director,	1 ☐ Yas 2	ΔÕΙΛΟ			ER/Outpatient		Othe	4 Li Nursing r	-	sidenca 8 🗆 C		fy)
or Attending Peter death. Director: After a in by the funer entification:	27. Manner of D 1 Natural 2 Acciden	5 Pending Investigation			28b. Time of Injury	M 280	Work	rat (? Yas 2 □ No		how injury occ		
tal or Attending P is efter death. al Director: After the led in by the funera Certification:	3 ☐ Suicida 4 ☐ Homicid	6 Could not be determined	28e. Ptace of Injubulding, etc.		ma, farm, strae	et, factory, o	office		28f. Location City or T	(Street and Nur own, State)	nber or Rur	al Routa Number,
b the Hospital or Attending Physician: Thin 24 hours efter death. The Funeral Director: After this cardificant left in the funeral director. Medical Certification: To Be (yalcian: To the best of tner: On the basis of and manner sta	examineti								
ALL		and title of cartifier				29c. l	icansa	number		29d. Date sign	ned (Month,	Day, Year)
100	30. Name and a	M, Ha	completed cause of de	mo eth (Item	23e) (Type, P		2312	24		Februa	ry 3,	1999
		M. Hannon					kvi	lle. Mar	yland 2	0852		
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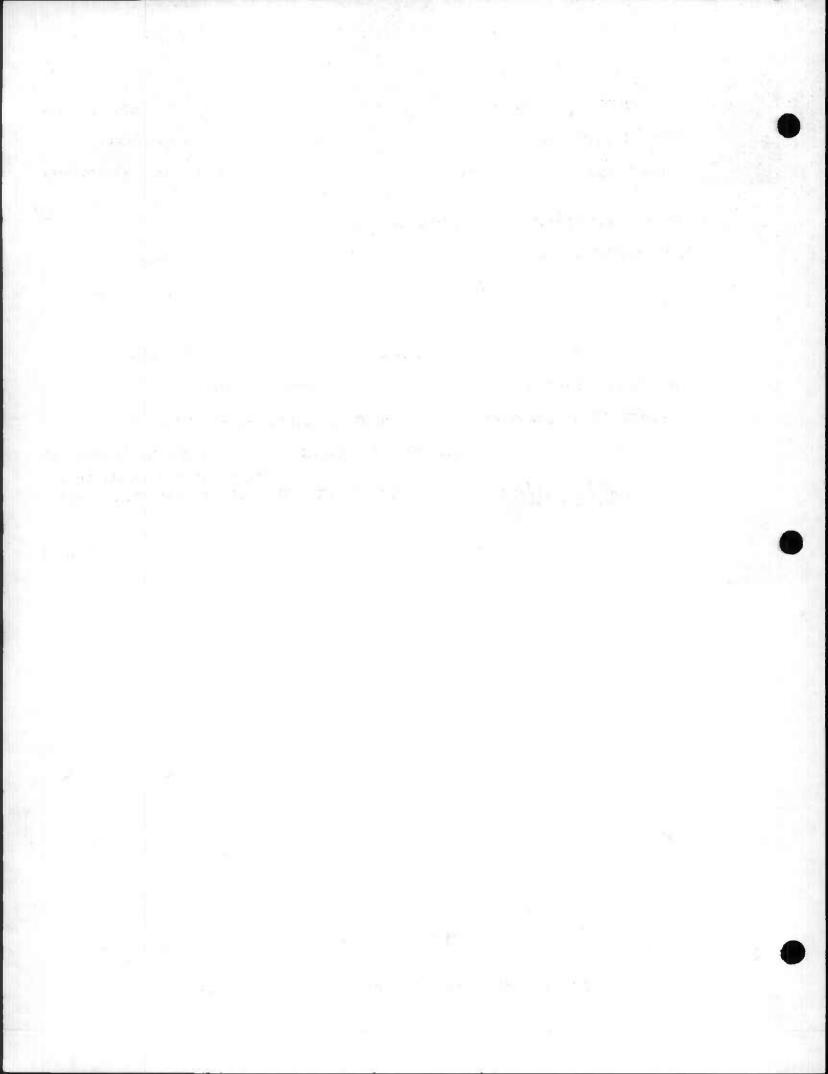
State of Maryland / Department of Health and Mental Hygiene

				Certificate of	Death	Re	og. No.	05438
	1. Decedant's Nama (First, Middla, La	ist)				2. Data of Deat	h	3. Time of Death
Physician	KENNETH	STABLER	KING			Month FEB.	Day Yes 1999	6:16 AM
 /Medical Examiner 	4a Facility Name (If not institution, giv		3444		4b. City, Town, or	Location of Death	4c. County of De	
	WASHINGTON	ADVENTIST :	HOSPITA	AL	TAKOMA F	PARK	MONTG	OMERY
Funeral			(In yrs. last bir	thday) If Under 1 Yaa Months Days	r If Under 24 Hrs	8. Date of Birth		Birthplace (State or Foreign Country)
Director	577-34-3754 Usual Residence of Decedent	1 ∑ M 2□F	70	Yrs.	110010	MAY 25	1928	WASHINGTON, D.
within 72 hours after death with the Meryland ena. Then "natural", or heme 23a or 28a-f show the Medical Examiner must be notified at the Medical Examiner must be notified at ompleted by Funeral Director	10a. State 10b. County		10c. City, Tow	n or Location				10d. inslda City Limits
Mer To	MD. PRINCE	GEORGES		ADELPHI				1 X Yas 2 □ No
or 28s-f e	10e. Street and Number			10f. Zip Code		10	og. Citizen of What	Country?
234	9250 EDWARI	OS WAY #41	0	2	0783		U.S	.A.
r tems 234	11. Marital Status	12. Was Decedent Ev Armed Forces?	ar in U,S.	13. Was Decedent of If Yes, specify Cu	Hispanic Orlgin? (S	Specify Yes or No-	14. Race - Ar Black, W	marican Indian,
al', or items 23a or 28a-f show Examiner must be notified at by Funeral Director	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No It Yes, Give	WWII	1 ☐ Yes 2 No		to mount, acc.,	Specify:	WHITE
ygiena. Ner than "natural", It, the Medical Ext. Completed by	15. Decedent's E (Specify only highest gra	ducetion		Decedent's Usuel Occu	upation e during most of wo	orkina	16b. Kind ot Busina	
then 'r	Elemantary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done life. DO NOT use retir	ed)			
Hygiene ther the	10			PLUMBER	Taxana a			VATE
d out	17. Father's Name (First, Middle, Last				18. Mother's Na	me (First, Middle, N		
5 th 0	JOHN	STERLING	KING					YSON
reumer	19a. Informant's Name/Relationship (19b	. Mailing Address (Street		,	City or Town, State	e, Zip Code)
tem 27 other tr	LUCY M. KING/WI	FE	COL CI	SAME AS	ITEM #	10	20-1	T
or off	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Ramoval from State	cemete	f Disposition (Name of ry, crematory or other pi	lece)	Date	20c. Location - City	or rown, State
any injury c	4 ☐ Donation 5 ☐ Other (Special		CULPI	EPER NATION	AL CEM.	2/11/99	CULPEPE	R, VA.
of the attending physician and actived for use as the bunal-transit and active as the bunal-transit and active active and active active active and active ac	Immediate Ceuse (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions of	c. Chreni	ua to (or as a d	consequence of): consequence of): consequence of): in the underlying cause of	Heres Failure Lung			30 minule 2 Weaks Several year, ute to the cause of death?
						1 Y	2 □ No 3 □	Probably 4 Unknown
should						24a. Was ar		b. Were autopsy tindings available prior to completion of cause of death?
E Se S						1□ Ye	s 20 No	1 Yes 2 No
rector, par Be Co	25. Was cese referred to medicel	1			26 Diago et C			
<u>o</u> o	exeminer?	Hospital:	2 ☐ ER/Ou	utpatient 3 DOA	ther	eath (Check only on Home 5 Reside		ingeita)
funeral tion:	27. Manner of Deeth 1 Whatural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b	28e. Date of Injury (Month, Day	Year) 28b.	Time ot 28c. Inj	ury et ork? ☐ Yes 2 ☐ No	28d. Describe ho	w Injury occurred	Rural Route Number,
led in by the	4 Homicide determined	building, etc.	(Specify)	, and an among the		City or Town	, Stete)	
completely filled in	29a. Certifier (Check only one) 1 Certifying Pt 2 Medical Exam	nysician: To the best of miner: On the basis of e end manner atete	xamination an	e, death occurred at the door investigation, in my	time, dete and plec opinion, death occ	e, and due to the ca curred at the time, da	ause(s) and manner ate and piece, end o	as stated. due to the ceuse(s)
To the Funeral Director: A completely filled in by the fr	29b. Signatura and itla of certifier	MD		DI.	8895	1	9d. Data signed (Mo	1 1000
41-	30. Name and address of person who MoBARAL KARIM,	7610 CAR	Roll	(Type, Print) AVENUS, TH	AKOMA 1	PAR12	1MD 2	0912
State Registrar	31. Dete tiled (Month, Day, Year)	32. Registrar	s Signature	B. Some	61			

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xamiı	ner	7910 KENTBURY DR					BETHESI			GOMER	y
neral			Sex 7. Age	(In yrs. les		nder 1 Year	If Under 24 H	rs. 8. Dete of Bi	rth		L ace (Stete or Fore try)
ctor		188-07-3954	1□ M 2 F {	35	Yrs.	ths Deys	Hours M		11 191	3PENNS	SYLVANIA
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fled	tor	MARYLAND MONTGOM	IERY	BETH	HESDA						1 □ Yes 2 🖔
28.00	Director	10e. Street end Number				. Zip Code			10g. Citizen of	Whet Coun	try?
reast		7910 KENTBURY DRI	_			20814			U.S.A		
edical Examiner must be notified at	by Funeral	11. Maritel Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Wes Decedent E Armed Forces? 1 ☐ Yes 2 ☒N If Yes, Give Yeer or Dates:			ecedent of H specify Cuba es 2 XNo	dispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)		ce - America ack, White, e	etc.
Signi	Completed	15. Decedent's E (Specify only highest g	Education rade completed)		16a. Decedent's (Give kind o	f work done	during most of w	vorking	16b. Kind of E	Business/Ind	ustry
the Medical	ldmo	Elementery/Secondary (0-12)	College (1-4or 5-		life. DO No	OT use retired	d)		OTDI HO	MTC	
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	To Be	JOHN CHALMERS MIE	RLEY				MARY E	THEL REE	D	,	
traumatic		19a. Informent's Name/Relationship DEBBIE NORTH (Rurel Route Numb		n, Stete, Zip	Code)
ther t		20a. Method of Disposition	DAUGHTEK)	20b. Plac	e of Disposition	(Neme of		LLE, MD.	20850 20c. Location	- City or To	wn State
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any In		21. Signeture of Funerel Service Llos Daniel S. L.	Alley					FFORDABLE #110 DU			
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completely filled in by the funeral		29b. Signature end title of certification	Lun	MD	>	04;	2423		02/	10/90	7



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 3. Time of Death 2. Data of Death Month Day **Physician** Koth Veren /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01 ney Montgomery | H Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) | Jan. 6 19 5. Social Sacurity Number Birthplace (Stete or Foreign Country) 6. Sax 7. Aga (In yrs. last birthday) **Funeral** 1□ M 2₩ F 219-64-1930 94 Yrs. 1905 Director Pennsylvania Usual Residenca of Decedant the Meryland pernit. Pages 1 and 2 should be filed within 72 hours after death with the Merylan Department of Heelih and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lighty or other traumatic event, the Medical Evantines must be notified at once. 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Directo Sandy Spring 10e. Streef end Number 10f. Zip Coda 10g. Citizan of What Country? 1616 Hickory Knoll Road 20860 United States Funeral 14. Race - Amarican Indian, Black, White, etc. 12. Was Decedenf Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ Yas 2 M No If Yas, Give Yaar or Datas: 1 Nevar Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Homema ker Own Home 12 Ω 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Melvin Luther French Caroline Hamlin To 19a. Informant's Nama/Ratationship (Type, Print) 19b. Mailing Addrass (Straat and Numbar or Rural Route Number, City or Town, State, Zip Code) Carol K. Thomas/daughter 19109 Brooke Grove Ct. Montgomery Village, Md. 20b. Plece of Disposition (Nama of cematary, cramatory or other place)
Metropolitan Crematory 20a. Mathod of Disposition Data 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 2/5/99 Alexandria, Virginia 4 Donation 5 ☐ Othar (Spacify) 22. Nama and Addrass of Facility
Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Maryland 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximata Intervel Between Onset end Daath **Physician** /Medical immediete Ceuse (Finat disaasa or condition rasulting in daath) 24h Examiner Due to (or es a consequanca of): Examiner physician and the buriel-transit The law requires that the death certificete be executed Sequantially list conditions, if any, leading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that Initiated avants resulting in daath) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): use as 1 ŏ ed by the a Part It. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings availabla prior fo completion of causa of death? should a 24e. Was an autopsy performad? Completed is certificate hes director, page 2 1 Yas 2 No 1 ☐ Yas 2 ☐ No or Attending Physician: 25. Wes case referred to medical axaminer? Be 26. Placa of Daath (Check only ona) Othar: 4 Nursing Homa 5 Residence 8 Othar (Specify) 2 1 Yas 2 No Inpatiant 2 ER/Outpatient 3 DOA this funeral 28a. Data of Injury (Month, Day Year) 27. Mannar of Daath 28d. Dascribe how Injury occurred 28b. Time of Certification: 28c. Injury at Work? 1 Natural 5 Panding 1 Yas 2 No efter death. Invastigation Director: A 2 Accident 6 Could not be determined 3 ☐ Sulcida Location (Streat and Number or Rurel Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) in 24 hour. the Funeral Direc-4 Homicida Hospital edical 29a. Cartifiar 🗷 Certifying Physician: To tha best of my knowledge, daath occurrad at tha tima, date and place, end due to the ceuse(s) and mannar as stated. completely 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only one) To the F within 2 29b. Signatura and title of certifing 29d. Data signad (Month, Day, Year) 29c. Licansa number 2/3/99 BC1082039 30. Name end eddress of person who completed sause of deeth (flem 23a) (Type, Print) 0 84.11.ps Da

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32. Registrer's Signature

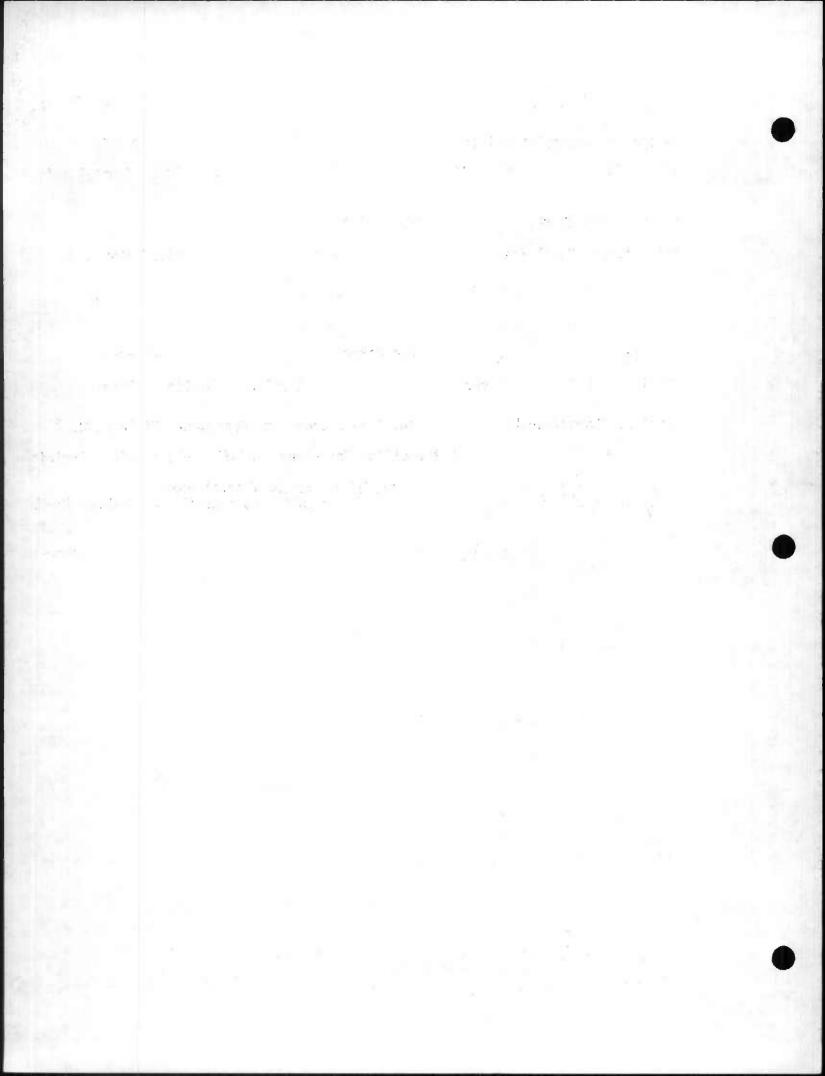
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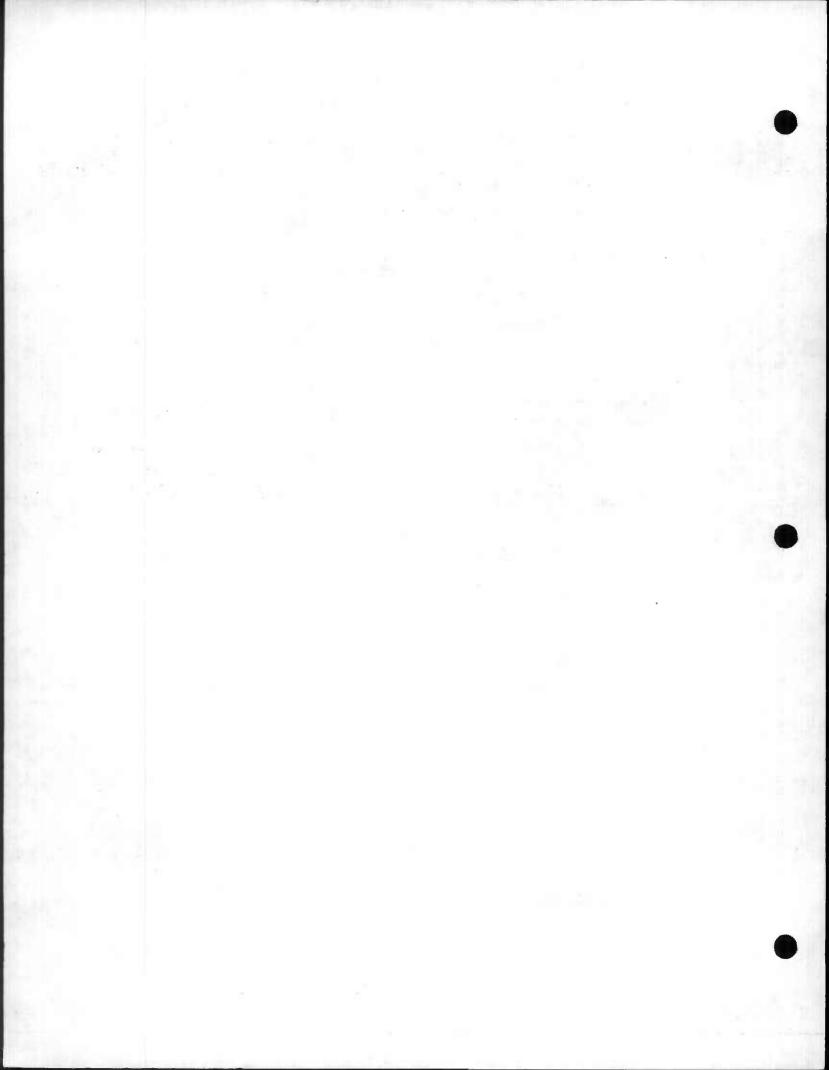
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31. Date filed (Month, Day, Year)



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To Be Completed by Funeral Director 10 De 110 11	suel Residence of Decedent a. State 10b. County claware Susse e. Street and Number R. D. 1 Box 163 Maritel Stetus 1 Never Merried 2 Merried 3 Microred 15. Decedent's (Specify only highest g Elemantery/Secondery (0-12) Fether's Neme (First, Middle, Last Manuel Vinnuel. Se. Informent's Neme/Raletionship Jillian Steele, a. Method of Disposition	Sex 7. Ag 10 M 2 N F 7. Ag 11 M 2 N F 7. Ag 12. Wes Decedent Armed Forces? 11 Yes 2 N Yes, Giva Yeer or Detes: Education rede completed) College (1-4or s) 1 st) a.	86 10c. City, OCE	st birthday) Yrs. Town or Lo 2 an Vi	Lew 10f. Zip Code 19	4b. City, Town, or Salisbut If Under 24 Hrs s Hours Min. 970 Hispanic Origin? (Sban, Mexican, Puer or Specify: Cul	B. Dete of Birth (Month, De) Jan. 1]	4c. County Wicon (Year) 1913 10g. Citizen of W US 14. Race Blec	of Death nico 9. Birthpia Countr Santi						
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	1. Signature of Funerel Service Licensee 22. Nama and Address of Fecility DeVol Funeral Home 2222 Wisconsin AVe., N.W. Washington, D.C. 20007														
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	3 Suicide 6 Could not detarmine		ury - At home. (Specify)	a, farm, str	eet, factory, office	•	28f. Location (S City or Tow	itreet and Numb m, Stete)	er or Rurel	Route Number,					
29	la. Certifier (Check only one) 1 Certifying P 2 Medical Exa	hystolen: To the best of the b	of my knowle examination	edge, death n end/or inv	occurred at tha vestigation, in my	tima, data and plece opinion, daath occ	a, and dua to tha curred et the time, o	causa(s) and ma data end place,	annar es sta end dua to t	ted. the ceuse(s)					
29	b. Signeture end title of certifier	2111		**	29c. Licer	nse number		29d. Date signed	d (Month, D	ey, Year)					
	1///	11/1/				20242		2/11	90						
-	. Name and addrass of person who	completed seven of d	eeth /Item o	Rel /Tunn		29349		11/	17						
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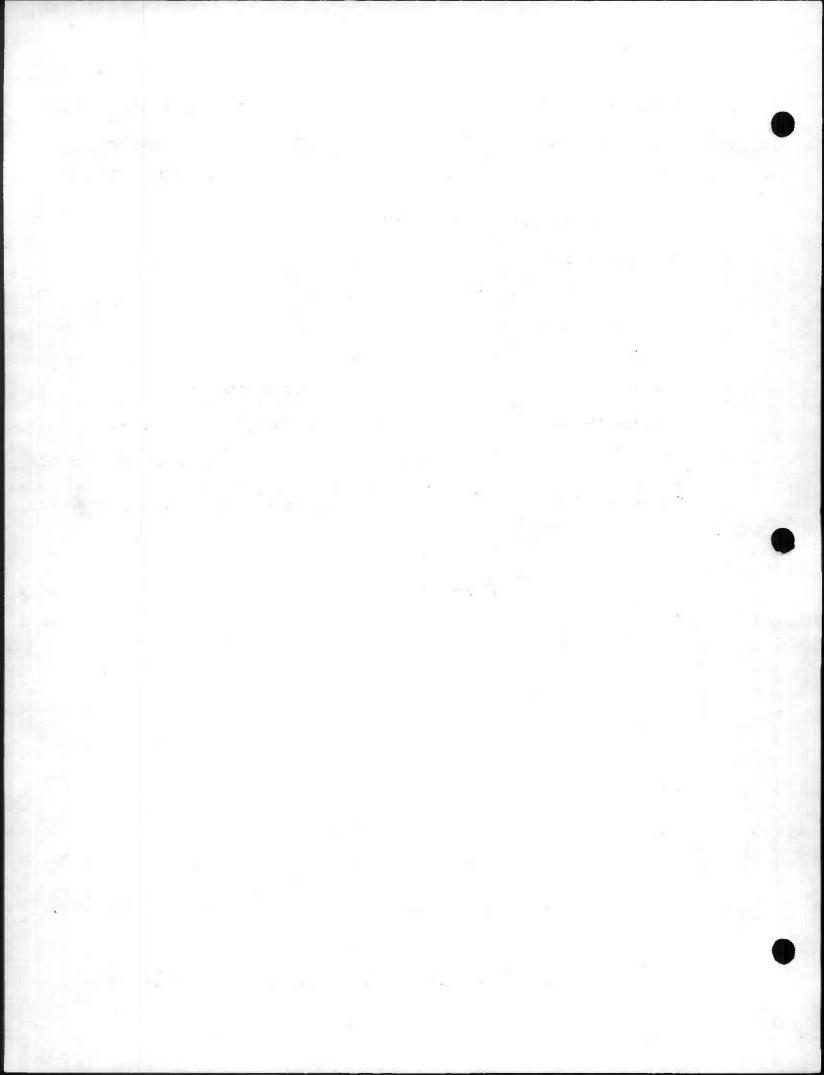
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day Year **Physician** Shirley Kramer February 9, 1999 5:15PM /Medical 4e Facility Neme (If not institution, giva street and number) 4b. City. Town. or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney If Under 24 Hrs. Hours Min. Montgomery If Under 1 Year 5. Social Sacurity Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1□M 2☑F Yrs. 88 Director 578-03-9269 May 17, 1910 Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or flems 23s or 28s-f show the Medical Exercises must be notified at 1 Yes 2 No Directo Maryland Montgomery Sandy Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18202 Slade School Road 14. Race - American Indian, White, etc. Funeral 20860 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Yes 2000 No If Yes, Giva Yaar or Datas: 1 Never Merried 2 Married ò Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐No Specify: p 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiane. Elementery/Secondary (0-12) College (1-4or 5+) 12 nd 2 should be filed vilth and Mental Hygia 27 is marked other traumatic event, if Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mothar's Nema (First, Middle, Meiden Sumema) Be permit. Pages 1 and 2 should be Department of Health and Mental important: if Nem 27 is marked a any injury or other traumatic events. Archie Hyman Esther Bernstein 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Paul Bran/Grandson 9505 Burning Tree Road, Bethesda, Maryland 20817 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, Stete Feb. 1 ☐ Burial 2 Cremation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 12,1999 Alexandria, Virginia Metropolitan Crematory 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Stein Hebrew Funeral Home 232 Carroll Street, NW, Washington, DC

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,

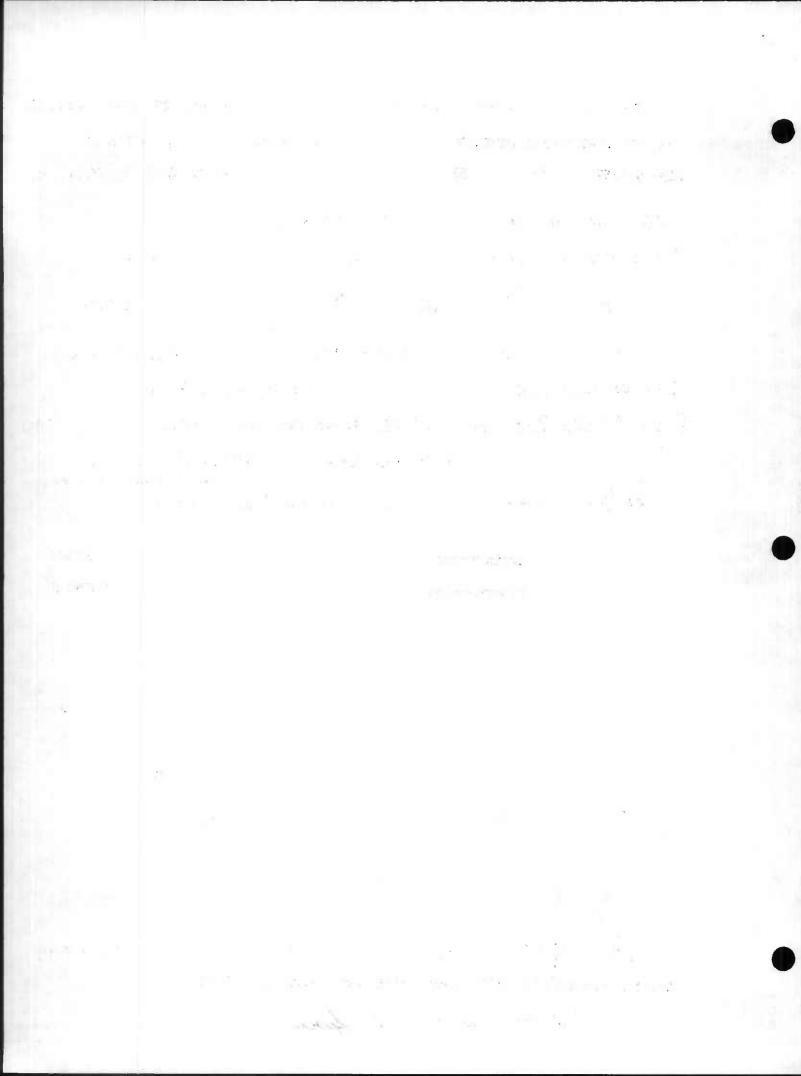
And the disease of the disease of the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,

And the disease of the disease of the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, 20012 Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or es e consequence of) Examiner neumonia burial-transit certificate be executed and Sequentially list conditions, if any, leeding to immediate causa. Enter Underlying Couse (Diseese or Injury that initieled events rasulting in death) Last Due to (or es e consequence of): Hypoxemia Box 68760 physician Physician/Medical Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy tindings available prior to completion of cause of death? should I 24a. Wes an eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this After thi funeral 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Netural 5 Pending n 24 hours after death.

Ne Funeral Director: After a function of the function 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicida 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical (Check only one) To the Within 2 29b. Signeture and title of-certifier 29c. License number 29d. Dete signed (Month, Dey, Year) waysus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Georgia Ave. Wheaten, MD 20902 Christoplar J. Ways MD 12002 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State Registrar

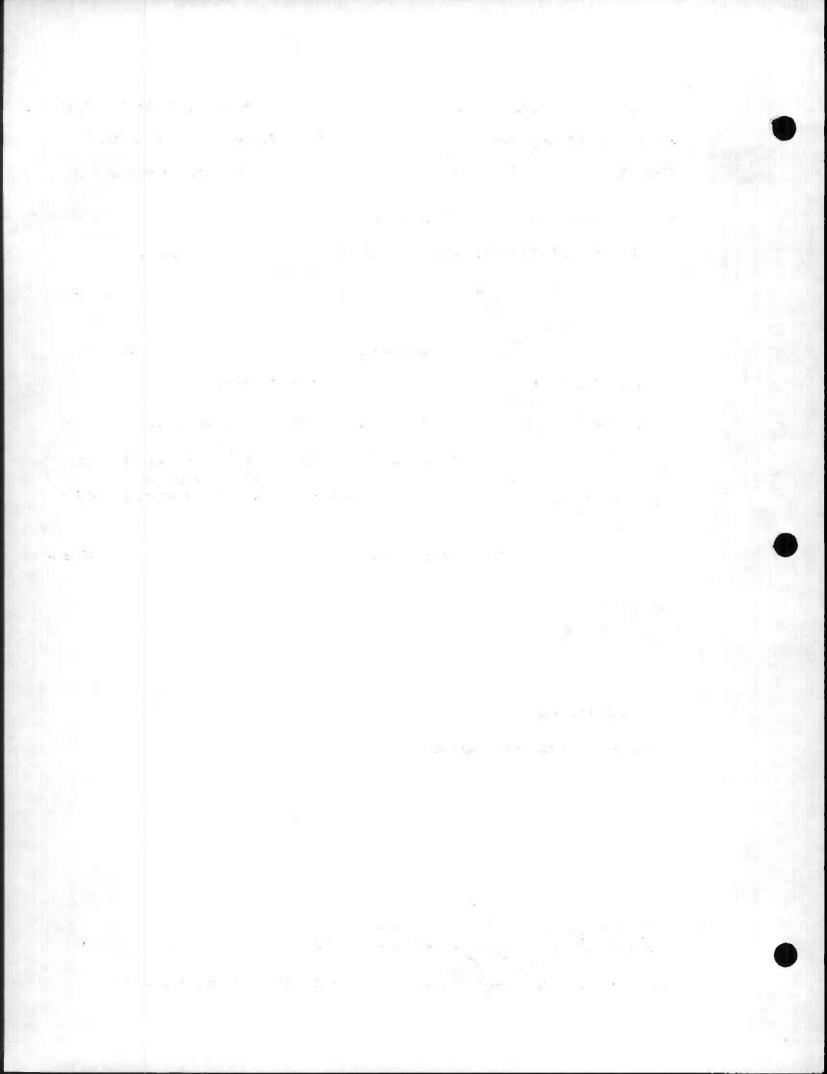


				Ce	ertificate of	lealth and l Death		Reg. No. 99	05	443
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	21. Signature of Fi	uneral Service Licen	500		22. Name and Addre	ss of Facility	FE	HUYLOG	groas	MP,
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	fmmediate Cause disaese or condition		Descion Manage						TINIK	NOWN
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			b. Hypertensi	on					UNK	MOMN
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	Funeral Director	5. Sociel Security 577-54-3	714	ex □ M 201 F	92	last birthday) Yrs.	Months Deys		Vin. (Month, D	ey, Year) 6 1906		lece (Stete or Foreign try) York
	pue 🖈	Usuel Residence	10b. County		10c. Cit	y, Town or Lo	cation				11	0d. Inside City Limits
	f she	D.C.	None		W.	ashing	ton					1 X Yes 2 □ No
	Tec 1	10e. Street end No	umber	100			10f. Zip Code			10g. Citizen of W	/het Coun	itry?
	3a o a a	4418	Greenwich	Parkway,	N.W.		20007			U.S.A.		
Maryland 21215-0020	permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mentle Hygiena. Intropriants if time 77 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evarities must be notified at once. To Be Completed by Funeral Director		rried 2 Merried 4 Divorced	12. Wes Decede Armed Force 1 Yes 2 If Yes, Give Year or Dete	s? No		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2K No	lispenic Origin en, Mexicen, P Specify:	? (Specify Yes or Nuerto Ricen, etc.)	o- 14. Race Blec Specify	- Americ k, White, Wh	
2-0	72 h	(Soe	15. Decedent's Ed			16e. Deced	dent's Usuel Occup kind of work done	pation during most of	workina	16b. Kind of Bu	siness/Inc	dustry
121	led within 72 ho ygjena. ner than "natura nt, the Medical I	Elementary/Sec		College (1-4c	or 5+)	life. I	DO NOT use retire	d)				
2	Cor British	47 Fathada Nama	/First Adiddle I and	4		House	wife	10 Mathada	Name /First Afiddl	Own Hon		
and	Ne Ne H		(First, Middle, Last) Schieffe						Neme <i>(First, Middl</i> Boardman	a, Maiden Sumam	Θ)	
Z	d Men Tranke		Neme/Rejetionship (10h Mailie	on Address (Street		or Rural Route Num	her City or Town	State 7in	Code)
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e,	Heal Heal Iam 2	20e. Method of Di		5011	20b. F		sition (Neme of metory or other pla		Dete	20c. Location -		
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Baltimore,	Departm Departm Importar any injur	-	unerel Service Licer		1100		2. Name end Addre	-		neral Ho		VIIgInia
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	/Medical Examiner	fmmediate Ceuse disease or conditi resulting in death	on	e. Alzh	eimer	s Dise	ease				1	18 months
		resulting in death,			Due to (d	r es e consec	quence of):					
1	nsit	de distribution		b		1007 307						
,	cata be axecuted physicien and the burletransit	Sequentially list of eny, leeding to locuse. Enter Und	onditions, mmediate		Due to (c	r es e consec	quence of):					
68760,	sicie e bur	Cause (Disease of that Initiated even	r injury ts	C	Due to (o	r es e conseq	luence of):			-		
68	a se a	resulting in deeth)	Lest				,				1	
Вох	death certification of for use as ilcian/Me			d								
0.	at the death certing by the attending etached for use a Physician/M	Pert II. Other sign	ificant conditions c	ontributing to death	but not res	ulting in the u	nderlying cause gi	ven in Pert t.	23b. Die	tobacco use cor	ntributa to	the causa of death?
٥.		Bron	nchiectasi	.s					10	Yes 2 No	3 Prol	bably 4 Unknown
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Record	The law requir	Chro	onic Lymph	ocytic L	eukem:	La				iormed?	av.	eliable prior to impletion of cause
Re	hes pe 2									Yes 2 No	1 20	death?
-	certificate h rector, page	25. Wes cese refe	aread to modioni					00 01			11	☐ Yes 2☐ No
Vital	Thysician: This certific rel director,	exeminer?		Hospital: 1 ☐ Inpe	ationt 2	EB/Outpation	nt 3 DOA Ot	hor ou	Death (Check only		er /Snecif	5c)
o	erel dire	27. Manner of Dee		28e. Dete of I	njury	28b. Time o			_	how injury occurr		y/
o	Attending or death. ector: After by the fune Ification	1 Naturel 2 Accident	5 Pending investigation		Dey Yeer)	Injury		Yes 2 □ No				
Division	tal or Attending P rs after death. al Director: After the ed in by the funere Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	288. Piece of	Injury - At he etc. (Specif	ome, farm, str	reet, factory, office			(Street end Numb own, Stete)	er or Rura	al Route Number,
	To the Neeptla or Attending Privation 2 to the Funeral Director: After this complately filled in by the funeral Medical Certification: 1	29a. Certifier (Check only one)			of examine				place, end due to the occurred at the time			
	omple	29b, Signature an	title of certifier	+ Silo married	Juliou.		29c. Licen	se number		29d. Dete signe	d (Month,	Day, Year)
	- 3 + ō	Va	Lent III	V KAL	111	west	D23	06		February	7 8.	1999
	0	30. Name and ad-	dress of parson who	completed cause	death (Iten	1 23a) (Type,	Print)					
			W. Langev	41	/		Ave. #11	25 Che	evy Chase	, Md. 208	815	
	State	31. Date filed (Mo	nth, Day, Year)	32. Flegi	strer's Signe		4		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	Registrar	F	EB 09 19	99	eneva	B.	Spark	21				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Deeth 3. Time of Death Month CLYDE LINDLEY 3 AM 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death WOODSIDE CENTERS SPRING. GENESIS SILVER MONTGONERY 5. Sociel Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Birthplece State or Foreign Country) 100 M 2 F Months Deys Hours Min 579-44-112 82 Yrs. Illinois Usuel Residence of Decedent 10a Stete 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No MD Montgomery Silver Spring 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? #809 2201 Colston Drive 20910 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give 13. Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ②No Specify: Yeer or Dates: 1941-75 Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Psychologist Veterans Administration 5+ 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Clyde Clifford Lindley Lillian Mary Brady 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Marie W. Lindley (wife) 2201 Colston Drive, #809, Silver SPring, MD 20910 20e. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State litan Crematory 2/6/99 Alexandria, Virginia 22. Name end Address of Feelilty Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Metropolitan Crematory 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee Home, Inc. 20901 Silver Spring, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete. Intervel Between Onset end Deeth Immediete Cause (Finel disease or condition resulting In death) EDSTATE + METASTASES HOENOCARCINOMA Due to (or es a consequence of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of): thet initieted events resulting in deeth) Lest Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown CHENMATO) HETHERITIS 24b. Were autopsy findings eveileble prior to 24a. Wes en eutopsy performed? completion of cause of death? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: Other: At Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menger of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Neturel 5 Pending investigation iniury 1 TYes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

The law requires that the deeth certificate be executed Box 68760, Records, P.O. Division of Vital Attending Physician: ŏ

Examiner burial-transi physician Physician/Medical the 9 ettending for usa es ed by the e signed b þ Completed has page 2 director. Be 2 this funeral Certification: After s effer dea. filled in by To the Hospital c within 24 hours er To the Funeral E Medical

Physician

/Medical

Examiner

.Funeral

Director

r than "natural", or itame 23a or 28a-f show the Medical Examinar must be notified at

Director

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Completed

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death

72 hours after

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permit. Pages 1 and 2 should be filled with Department of Health end Mental Hygian important: if Item 27 is marked other that any injury or other traumation.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0020

State

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

4 Homicide

(Check only one) 29b. Signeture

29a. Certifier

MD

1999

10801 LOCICWODD 32. Registrer's Signature

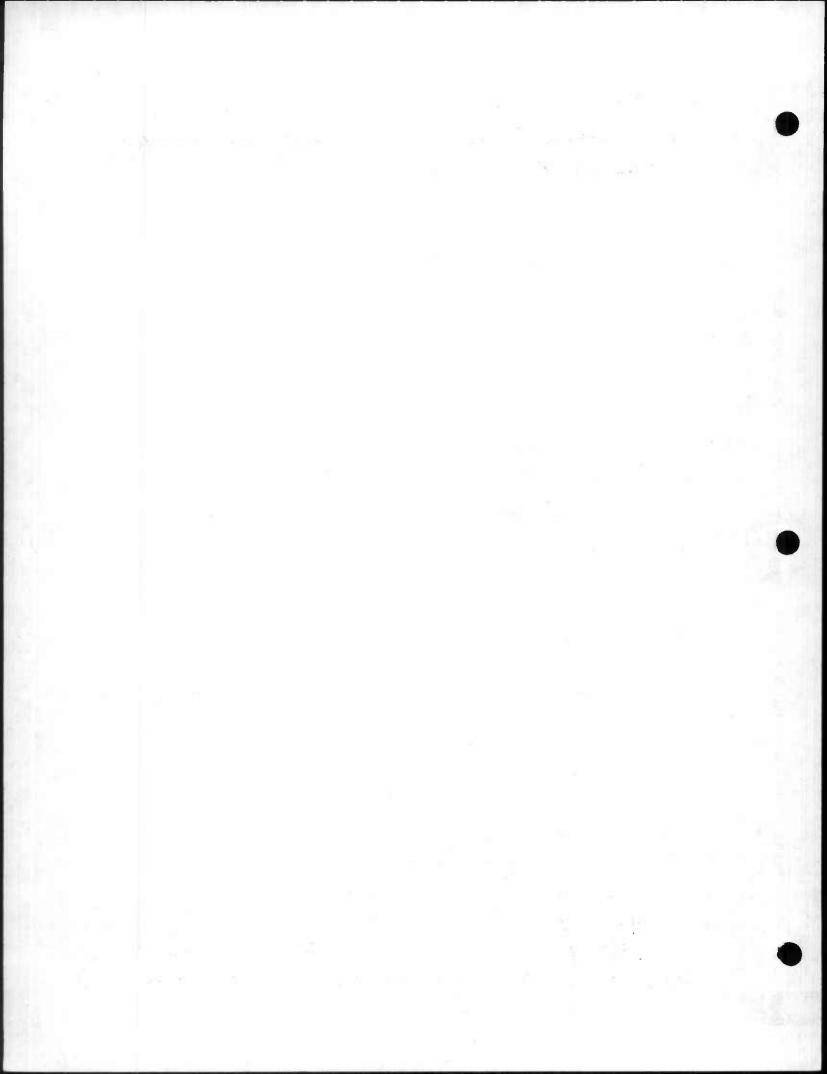
1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) and menner es stated.
2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner stated.

29c. License number

29d. Date signed (Month, Dey, Year)

6

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month February 1999 Edward Eugene Linehan, Sr. 10:00 AM 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 20111 Waterside Drive Germantown Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 1 → M 2 → F 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Days Months Hours 78 Nov. 9 1920 Massachusetts 030-09-1844 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 Nes 2 No Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20111 Waterside Drive 20874 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Tyes 2 No If Yes, Give Year or Dates:1942/1947 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White 3 N Widowed 4 □ Divorced 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Contract Specialist Federal Government 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Richard Joseph Linehan Alice Phelan 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Joseph R. Linehan/Son 607 Anderson Avenue, Rockville, Maryland 20850 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Locetion - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 2-8-99 Silver Spring, Md. 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licenses 10 E. Deer Park Dr. Gaithersburg, Md. 20877 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Cause (Final disease or condition resulting in deeth) Acute Myocardial Infarct Due to (or es a consequence of): 10 years Coronary Artery Disease Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No 1 Yes 2 No 25. Wes case referred to medicel examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ₺ Residence 6 ☐ Other (Specify) 1⊠ Yes 2□ No 28a. Date of Injury (Month, Dey Yeer) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 Natural investigetion 1 ☐ Yes 2 ☐ No 2 Accident

physician and is the burial-transit certificata be executed Box 68760, 60 US8 for signed by the a P.0. that the Division of Vital Records, should b page 2 s cartificate has director this funeral After t or Attending eftar death. Director: Aft filled in by

Physician

/Medical

Examiner

10a. State

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Funeral

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Completed

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Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours efter the Department of Health and Mantal Hygiona. Important: If Item 27 is marked other than "natural", or item any finlury or other traumatic event, the Mantal Examina

Physician

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Certification:

edical

3 Suicide

4 Homicide

Baltimore, Maryland 21215-0020

with the Maryland

death

Hospital 24 hours completaly To the within 2 To the 10+

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifie February 5, 1999

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

tho completed cause of death (Item 23a) (Type, Print)

5530 Wisconsin Ave. #925 Chevy Chase, Maryland 20815 James Poster, M.D. 31. Date filed (Month, Day, Yeer)

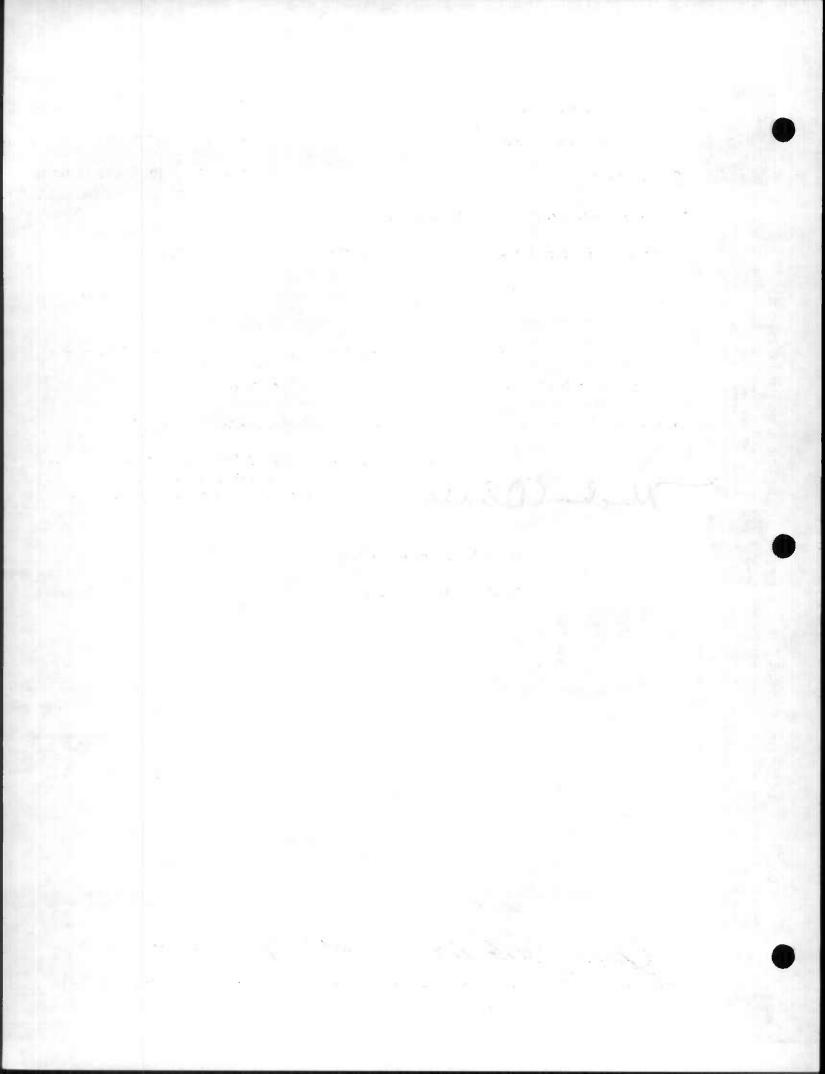
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

State Registrar

FEB 0 9 1999

6 Could not be determined

32. Registrer's Signature oouks



Physician /Medicat **Examiner**

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

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lith and Mental Hygiene. 27 is marked other than "r r traumatic event, the Mer

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permit. Page Department of Important: If any Injury or once.

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death

filed within 72 hours after

Baltimore. Maryland 21215-0020

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Physician/Medical by Completed Be 10 Certification:

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A 24 hour. Funerel P Hospital 24 hours 6

To the Hosp within 24 ho To the Fune completely f

12

Attending

or Attending efter death. Director: Aft

Division of Vital Records,

1 ☐ Yes 2 No 1 ☐ Yes 2 No. 25. Was case referred to medical examiner? 26. Plece of Death (Check only ona) Othar: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Y☐ Yes 2☐ No 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending invastigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, atc. (Spacify) 4 Homicide 29a. Certifier 1 Certifying Physician: To tha bast of my knowledga, daath occurrad at tha tima, data and pleca, and due to tha causa(s) and mannar as statad. 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end mennar stated.

Medicai 29b. Signature

OM & M.O. 30. Nama and eddress of person who completed cause of deeth (Itam 23a) (Type, Print)

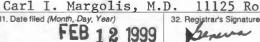
11125 Rockville Pike, Rockville, Maryland 20852-3142

29d. Date signed (Month, Day, Year)

February 5, 1999

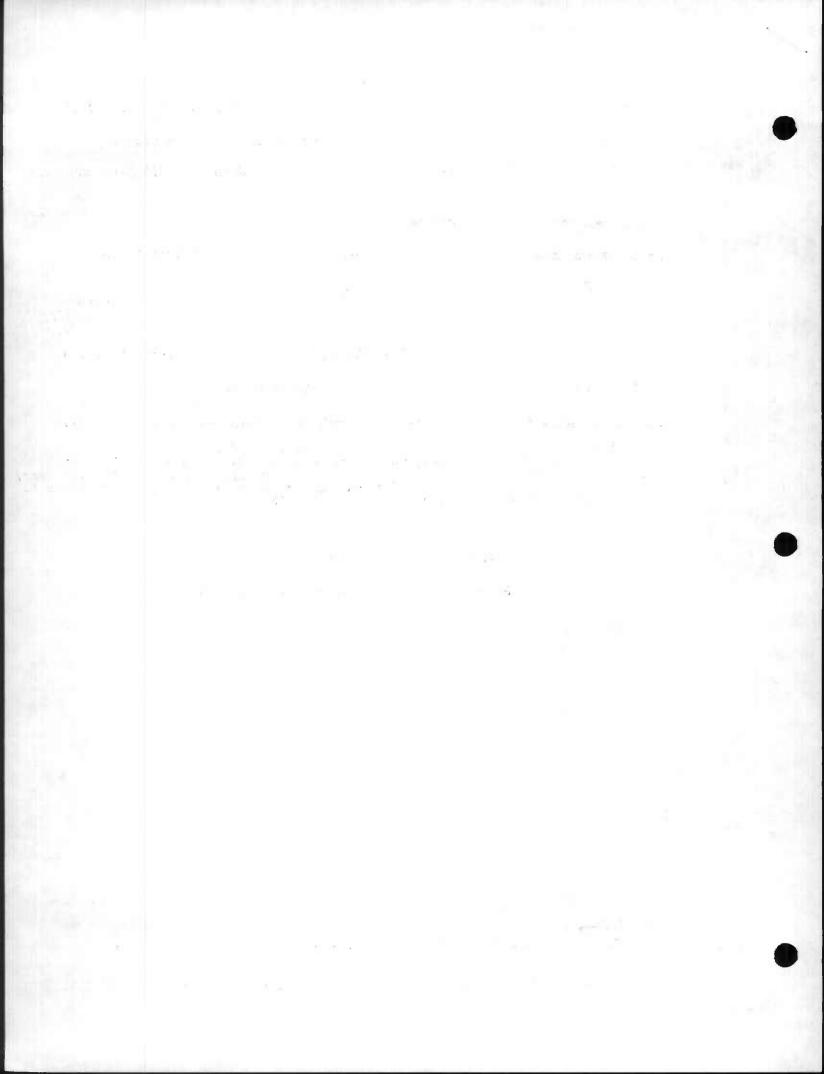
State Registrar 31. Date filed (Month, Day, Year) FEB 12

title of certifier



29c. Licensa number

D15236



Physician /Medical Examiner

Eugene

1. Decedent's Nama (First, Middle, Last)

Lyons

Day Month 7, Feb. 1999

4c. County of Death

Howard

10g. Citizen of What Country?

Specify

United States

16b. Kind of Business/Industry

20c. Location - City or Town, State

29d. Date signed (Month, Dey, Year)

February 8, 1999

14. Raca - American Indian, Black, White, etc.

United States Army

White

Dondlinger

Approximate Interval Between Onset and Death

2 Menths

3. Tima of Death 7:00A.

9. Birthplaca (Stata or Foraign

10d. Inside City Limits

1 ☐ Yes 2XXVo

Illinois

Funeral

Director the Maryland

? is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examiner must be notified at Hygiene. permit. Pagas 1 and 2 should be file Department of Health and Mental Hy, important: if item 27 is marked othe any injury or other traumatic event, blocs.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

physician and the burial-transit certificata be axecu use as 1 cartificata has Aftari or Attending death. tha after deat Director:

Box 68760,

Division of Vital Records,

To the Hospitai

filled in by 24 hours within 24 how To the Fune complately fi

Examiner Physician/Medical þ Completed Be To Certification: edical

4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 9141 Gracious End Court, #103 Columbia If Under 1 Year | If Under 24 Hrs. 6. Sex. XXM 2□ F 8. Date of Birth Month, Dev Year July8,1922 5. Social Security Number 7. Aga (In yrs. lest birthdey) Hours Months Days 76 Yrs. 322-12-2696 Usual Residance of Decedent 10c, City, Town or Location 10a. State 10b. County Columbia Howard Maryland Director 10e. Street and Number 10f Zio Code 9141 Gracious End Court, #103 21046 Funeral 13. Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Nevar Married X Married 1 ☐ Yes XX No Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) U.S. Army Officer 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fathar's Name (First, Middle, Last) Be John Martha Lyons 2 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary C. Lyons (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Arlington National Cemetery 2/16/1999 Arlington, Virginia 22 Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. efferentiated Esophageal Cancer
onsequence of):
Letastares / ascites Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated avents resulting in death) Last Due to (or as a consequence of): Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. eary exactly - ideo pathe

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 20XNo 1 ☐ Yes 2KXVo 25. Was case referred to medical/ examiner? 26. Place of Death (Check only one) 1 Yes 218 No 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 ☐ Homicide **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one)

State Registrar

31. Date filed (Month Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

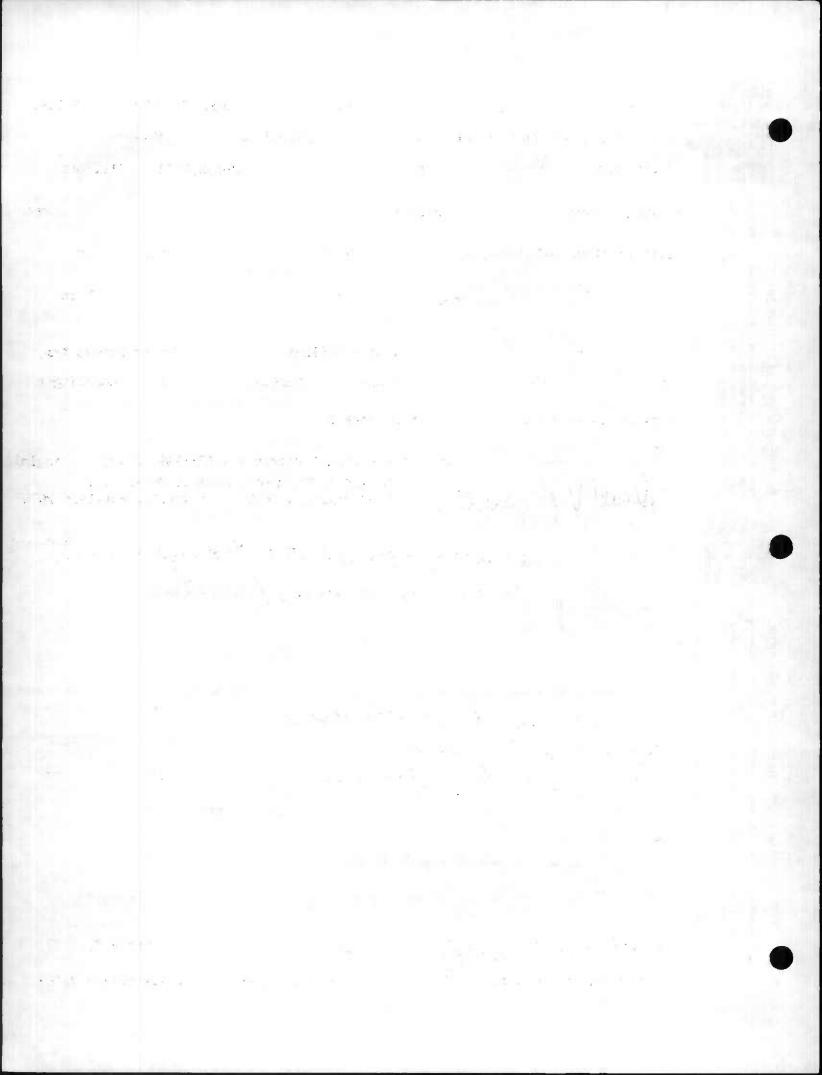
29b. Signature and title of certifier

32. Registrar's Signature

Richard Kolodrubetz, M.D. 9501 Old Annapolis Road Ellicott City, Maryland 21043

29c. License number

031575



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** FEBRUARY 04, 1999 7:30 A.M. PHYLLIS W. MALONEY /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner SILVER SPRING MONTGOMERY 1612 WOODWELL ROAD If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In vrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthpiece (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 🗲 Months Deys Hours 87 Yrs. Director OCT. 22, 1911 NEBRASKA 577-34-5586 Usuel Residence of Decedent 10a State 10b. County 10c. Cltv. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Madical Examinar must be notified at 1 ☐ Yes XIX No Director MARYLAND MONTGOMERY SILVER SPRING 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number permit. Peges 1 and 2 should be filed within 72 hours aftar death with Department of Health and Mental Hygiane. Important: If Item 27 is merked other than any figury or other traument. UNITED STATES OF AMERICA 20906 Funeral 1612 WOODWELL ROAD 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 XXVo If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. 11. Maritel Stetus Black, White, etc. 1 □ Never Married 2 □ Married 1 Yes 2XXNo Specify: Specify: à 3XXWidowed 4 □ Divorced WHITE Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) OWN HOME 12th HOME MAKER 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be CLAUDE CLEVELAND GRIMES AMANDA HEESCH 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1612 WOODWELL ROAD SILVER SPRING MARYLAND 20906 RONALD S. MALONEY (SON) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete FEB.05, 1 ☐ Buriel 2XX remetion 3 ☐ Removel from State CREMATORY 1999 FAIRFAX VIRGINIA
22. Name end Address of Fecility HINES-RINALDI FUNERAL HOME,
11800 NEW HAMPSHIRE AVENUE 4 ☐ Donetion 5 ☐ Other (Specify) EVERLY CREMATORY INC. 21. Signal of Funerel Service Ligensei Mal SILVER SPRING MARYLAND 20904-2891 Approximate Intervel Between Onset end Death ther the disease, or complications that deused the dem heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory errest, **Physician** /Medical disease or condition resulting in death) Examiner Examiner physician end the buriel-trans Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequença of): Physician/Medical Due to (or es e consequence of): as esn 0 ed by the datached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2□ No 3 Probably 4 Unknown signed t þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Was en eutopsy performed? Completed page 2 s certificata has 1 ☐ Yes 2 ☐ No 1 Yes' 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) ome 5 Residenca 6 Other (Specify)
28d. Describe how injury occurred Other: 4 Nursing Home 1 Yes 2 ¥ OL No 1 Inpatient 2 ER/Outpetient 3 DOA After this funaral 27 Menner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Certification: Naturel 2 Accident 5 Pending investigation

28f. Location (Street end Number or Rural Route Number, City or Town, State)

6 Could not be 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

crifying Physician: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the ceuse(s) end menner as steted.

2 | Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner steted. 29c. License number 29d. Date signed (Month, Day, Year)

death (Item 23a) (Type, Print)

1999

Registrar

Medical

EB 0 8

3 Suicide

29a, Certifier

4 Homicide

32. Registrer's Signeture

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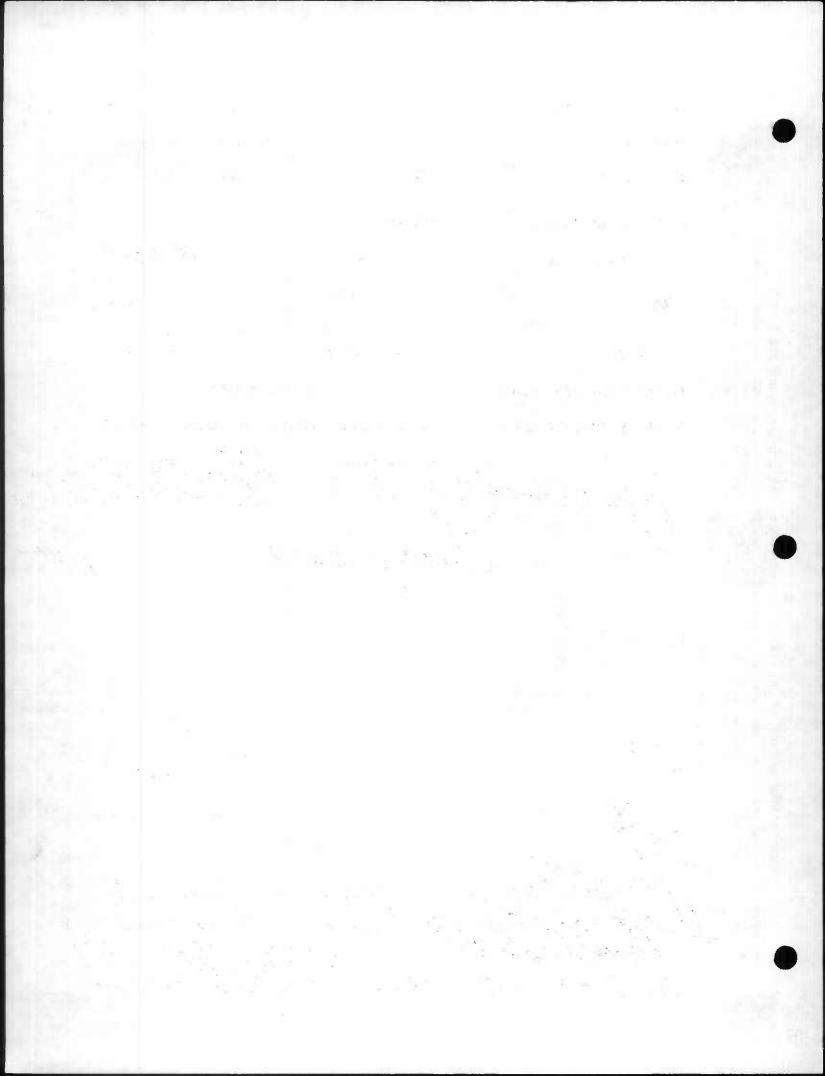
Division of Vital Records,

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State of Maryland / Department of Health and Mental Hygiene

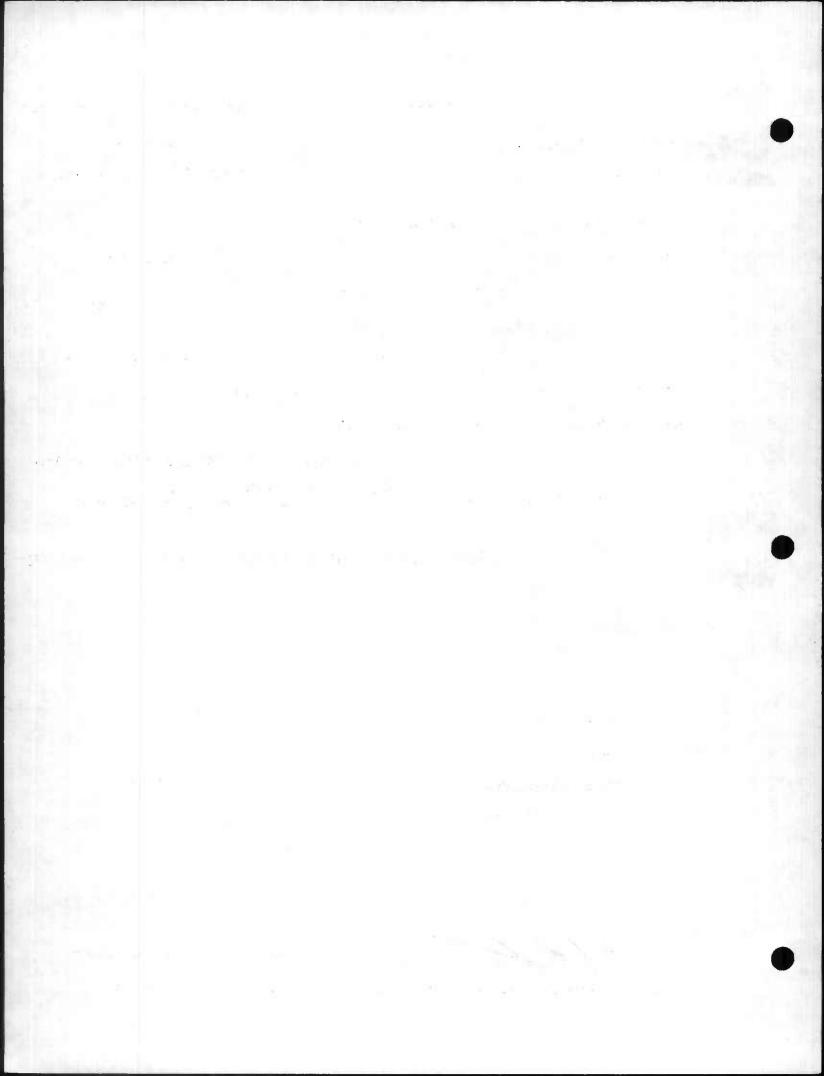
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State of Maryland / Department of Health and Mental Hygiene

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CHAI		Mary Ann Bacon	(daughter)	Sar	me as	LO			
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/Medic Examin	ner	Immediate Cause (Final disease or condition resulting in death)	a. SEAFR	Due to (or es e con		Mojorn	C) hullenoh	EDIOPARTHA) 14 4 Fars
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10		30. Neme end eddress of person who d	ompleted cause of de	eth (Item 23e) (Tv	pe, Print)	V-1 /4	-	1 MIKUTTE	7,1771
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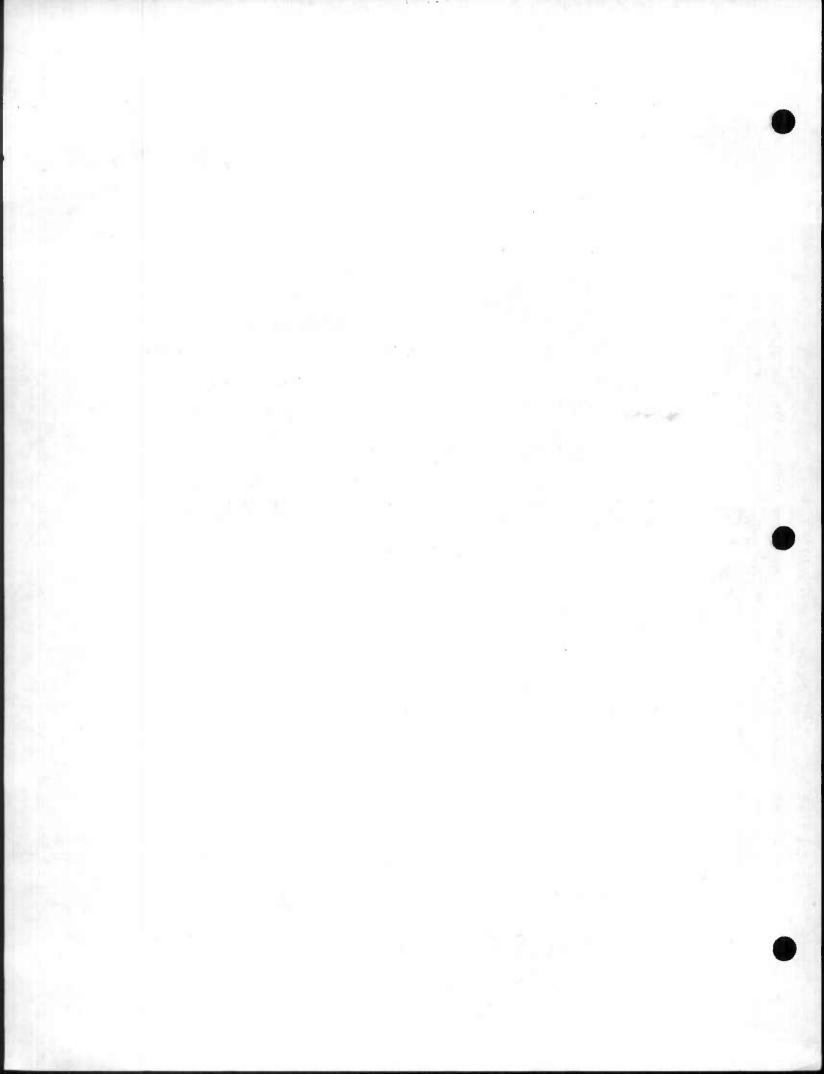


State of Maryland / Department of Health and Mental Hygiene

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nysician Medical	Joseph O. Mat	thews							Februa				00 p.m
kaminer	4a Facility Neme (If not institution,	give street and nu	ımber)				4b. City, To	wn, or L	ocation of Deat	h 4c. Co	ounty of De	ath	
	Suburban Hospit	al .					Bethe			Me	ontgo	mery	
eral ctor	5. Sociel Security Number 233–30–3471	. Sex 1 ⋅ M 2 □ F	7. Age (In yr.	s. last birthday Yrs.	Months	1 Year Days		Min.	8. Date of Bi Month, Di MAY 13	y, Year)	9. B WE	intholace (S country) SI VII	RGINIA
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tor	MD 10a. Stete 10b. County MONTGON	MERY		City, Town or L THESDA	ocation.							~	ide City Limits Yes 2 □ No
l'ec	10e. Street and Number				10f. Zip	Code				10g. Citizer	of What C	Country?	
le.	9707 OLD GEROGET	OWN ROAD			208	14				U.S.A	١.		
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	15. Decedent's	Education		16a. Dec	edent's Usu	el Occup	pation			16b. Kind	of Busines	s/Industry	
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	3 ☐ Suicide 6 ☐ Could not determine	208. PIBCE	e of Injury - At ling, etc. (Spec	home, farm, s cify)	treet, factor	y, office	7.		28f. Location (City or To	(Street and I wn, State)	Number or i	Rural Route	Number,
edicai (29a. Certifier (Check only one) 1 Certifying I	Physician: To the arminer: On the b	best of my kr easis of examination	nowledge, dee nation and/or i	th occurred nvestigetion	et the ti	me, date er opinion, des	nd place, oth occur	and due to the red at the time,	cause(s) ar date and pl	nd manner ace, and d	as stated. ue to the ca	use(s)
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	30. Neme end address of person wh	o completed caus	se of death (Ite	em 23a) (Type	, Print) LE	WIS	CAHI	LL,	M.D.				
	6000 EXECUTIV	E BLVD,	ROCKVI	LLE, M	ARYLAN	ID 2	0852						
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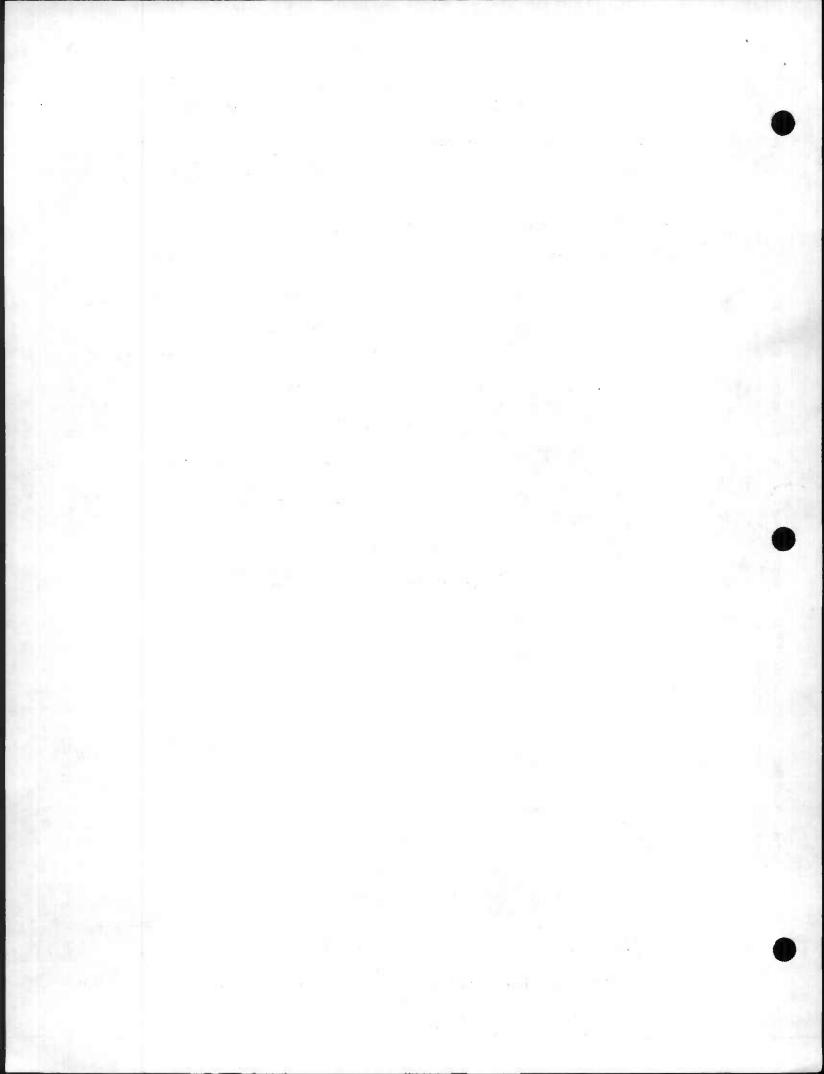
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #23a.2/16/99. BMW, Montg. Co. per physician Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death Month Dev **Physician** Geraldine D. McDonald February 1999 12:10 AM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Woodside Center Genesis Healthcare Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthpleca (Stete or Foreign Country) **Funeral** 10 M 2 F Deys Months Yrs. 210-18-5252 90 Director 25, 1908 Pennsylvania Dec. Usuel Residence of Decedent the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f ahow edical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? WITH 11517 Lovejoy Street 20902 Funeral United States death 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Maritel Status e filed within 72 hours after of Hygiene.
other than "natural", or item 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 NWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Doctor's Office Secretary permit. Peges 1 and 2 should be file Department of Health and Mentel Hy, Important: If item 27 is marked othe any Injury or other traumatic event, bluce. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Wellington E. Fitzgerald Hattie J. Walters 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Jane Shotkin (daughter) Same as 10 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Pine Grove Cemetery 2-10-99 Russell, Pennsylvania 21. Signeture of Funerel Service Licansee 22. Name and Address of Facility
Rapp Funeral Services, P. A. allen 933 Gist Avenue, Silver Spring, MD 20910 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heer failure. List only one cause on each line. **Approximete** nterval Between Onset and Death **Physician** Organic brain syndrome with failure to thrive /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Ventricular Arrhythmia Examiner Due to (or es a consequence of): Senile dementia Physician/Medical Examiner Atherosclerotic Vascular Disease physician and s the bunal-transit The lew requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es a consequenca of): Depression. Di Box 68760, thet initiated events resulting in death) Last Due to (or es e consequence of) Morbid Obesity 980 D.0 Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2X No 3 Probably 4 Unknown Records. þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Wes an autopsy performed? page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 🕅 No of Vital Physician: Be 25. Wes case referred to medical 26. Placa of Deeth (Check only one) Hospitel: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Division or Attending 1 Netural 5 Pending investigation Injury s after dea. 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rurel Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours of To the Funeral I 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end placa, and due to the cause(s) and menner stated. 29a. Certifier completely one) 29b. Signatur and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 3 D24886 February 8, 1999 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Mark H. Eig, M.D., 10801 Lockwood Drive, #280, Silver Spring, Maryland 20901 31. Date filed (Month, Day, Year) FEB 0 8 32. Registrer's Signeture State

DHMH 16 Rev 6/95

Registrar

1999



		Certi	ficate of	Death			Reg. No.		C
1. Decedent's Name (First, Middle, Last)				1	2. Date of De Month		Year	3. Time of Death
Margaret O. Mea	ans				F	ebrua		999	6:00 PM
ta Facility Name (If not institution, give	street and number)			4b. City, Town,				nty of Death	1
Holy Cross Hospi				Silver	Spr	ing	Mor	itgome	ry
5. Social Security Number 6. Se	M 2⊠F	Yrs A	If Under 1 Year Months Days			3. Date of Bir (Month, Da		Cou	nplace (State or Forei untry)
577-24-9461 Usual Residence of Decedent	7	4 113.			F	eb. 26	, 1924	Vir	ginia
10a. State 10b. County	10c. City	, Town or Local	tion						10d. Inside City Limi
Maryland Montgomer	^37	Silver	Spring						1 ☐ Yes 2 ☑ N
10e. Street and Number	,	DILVEL	10f. Zip Code				10g. Citizen	of What Cou	untry?
11502 Joseph Mill	Road		20	906			U.S.	Α	
11. Marital Status	12. Was Decedent Ever in U.; Armed Forces?	S. 13. Wa	s Decedent of I		? (Spec	ify Yes or No	- 14. F	Raca - Ameri Black, White	
1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2 ☑ No If Yes, Give		Yes 2 No			,,	Spe		, 0.0.
3 ☐ Widowed 4 ☐ Divorced	Year or Dates:							Whi	
15. Decedent's Edu (Specify only highest grad		(Give kin	nt's Usual Occup nd of work done NOT use retire	during most of	working	g	16b. Kind o	f Business/Ir	ndustry
Elementery/Secondery (0-12)	College (1-4or 5+)			(4)					
10 17. Father's Name (First, Middle, Last)		meat W	rapper	18. Mother's	Name	(First, Middle	Grocer Meiden Sun		re
Charles M. Jollett		/		100					
19a. Informant's Name/Relationship (T)		19b. Mailing	Address (Street	t end Number o	r Rural	Route Numb	er, City or To	wn, State, Zi	^(ip Code) 20906
James A. Means, Sr									
20a. Method of Disposition	20b. Pl	11502 J lace of Dispositi emetery, cremat	ion (Name of		i	Date	Sprin 20c. Locatio	on - City or T	y Land Town, State
1 ☑ Bunal 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State					/8/99	0.1.1		
21. Signatury Funeral Service Ligens	wasi	nington	Nation lame and Addre		ter	у	Suitla	nd, Mai	ryland
//	// //								
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23a. Part I Enter the disease, or como shock, or heart failure. List only o	ications thet caused the death ne cause on each line.	500 Do not enter	ncis J. Univer the mode of dyi	0 111	ns F Lvd. rdiac or	uneral ,W.,Si respiratory a	Home, lver S	Inc.	MD 20901 Approximete Interval Between Onset and Death
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Physician · /Medica Examine

Funeral Director

Department of Health and Mental Hygiene, important it is the 27 is marked other than "natural", or items 23s or 28s-4 show with injury or other traumatic event, the Medical Examiner must be nomined at other.

Physician /Medical **Examiner**

signed by the attending physician end Id be detached for use as the burial-transit

pompletely filled in by the funeral director, page 2 should be detached for

To the Hospital or Attending Physician: The law requivitin 24 hours after death.

To the Funeral Director: After this certificate hes been

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

State Registrar

31. Date filed (Month, Day, Year) FEB 0 8 1999

1 24 1 5 1

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Maria Camila (Camilu) Astorga Meekins Feb. 4,1999 3:07pm /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 24 Hrs. Hours | Min. 5. Sociel Security Number 7. Age (In vrs. last birthday) If Under 1 Year Birthplace (Stete or Foreign Country) 8. Date of Birth (Month, Dev. Year) Funeral 10 M 20 F Months Deys 73 219-92-2249 Nov. 6, 1925 Nicaragua Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f ahow other traumatic event, the Medical Examiner must be notified at Md Potomac Montgomery 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 2204 Chilham Place 20854 United States Nerna 23a death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No if Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11 Marital Status pernit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ther any injury or other traumatic event, the Messires. 1 ☐ Never Merried 2 ☒ Married Baitimore, Maryland 21215-0020 1 X Yes 2 No Specify: Nicaraguan Specify: White P 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Embassy of Elementery/Secondary (0-12) College (1-4or 5+) Diplomat Nicaragua 4 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be Luciano Astorga Lydia Calonje 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Daniel C. Meekins Jr. (Husband) 2204 Chilham Pl. Potomac, Md. 20854 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Steta 20a. Method of Disposition Date Feb. 11 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State Silver Spring, Md. Gate of Heaven Cemetery 4 Donetion 5 Other (Specify) 1999 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service License 10 East Deer Park Dr. Gaithersburg, Md. 20877 Weles 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Cardio-respiratory Arrest Examiner Due to (or as a consequence of): Examiner Acute Myocardial Infarction 4-6hrs. attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence of): Colonic Perforation Box 68760. Physician/Medical Due to (or es e consequence of): Sepsis P.O. 23b. Did tobacco use contribute to the cause of death? the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 1 Yes 2 No 3 Probably 4 Unknown Systemic Lupus Erythematosis Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Insulin Dependent Diabetes Mellitus pege 2 certificate has 1 ☐ Yes 2 X No 1 ☐ Yes 2 ◯XNo 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2♥ No this 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral edical Certification: 28c. Injury at Work? Affer 1 (Neture) 5 Panding 1□Yes 2□No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D48043 Inaion 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sharon A. Scanlon M.D. 5100 Wisconsin Ave N.W. #400 Wash. D.C. 20016

Registrar

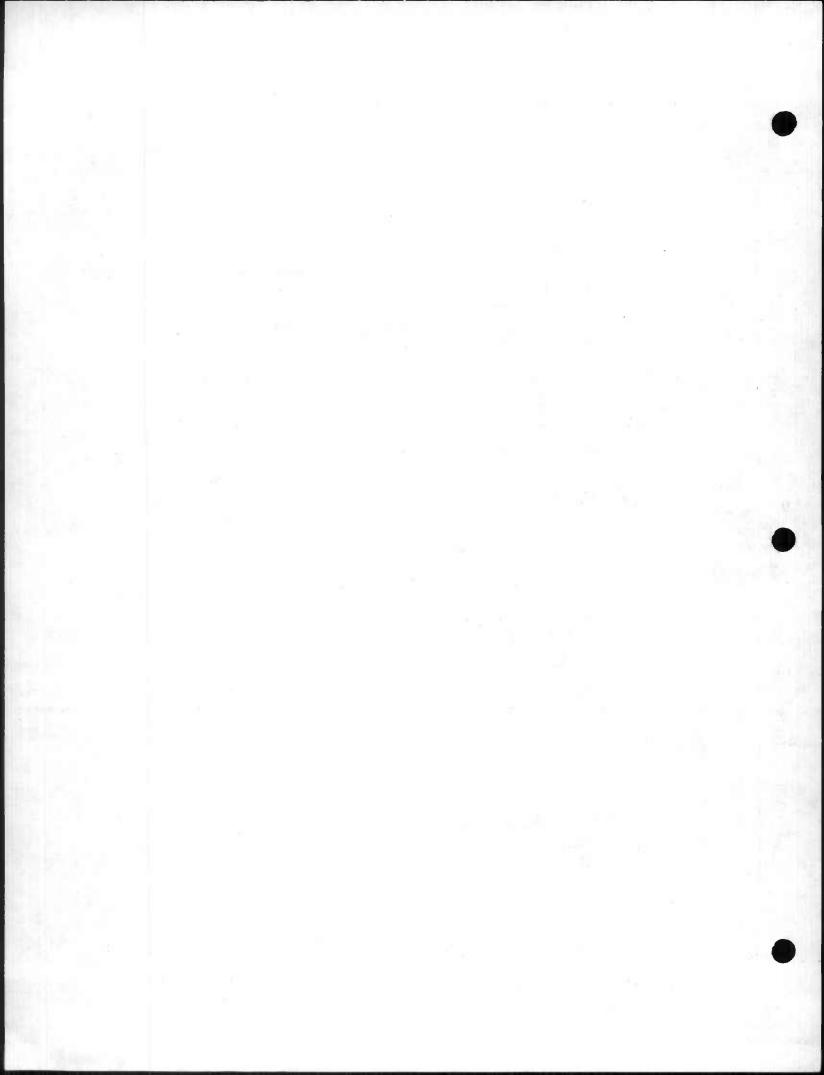
State

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31. Date filed (Month, Dey, Year)

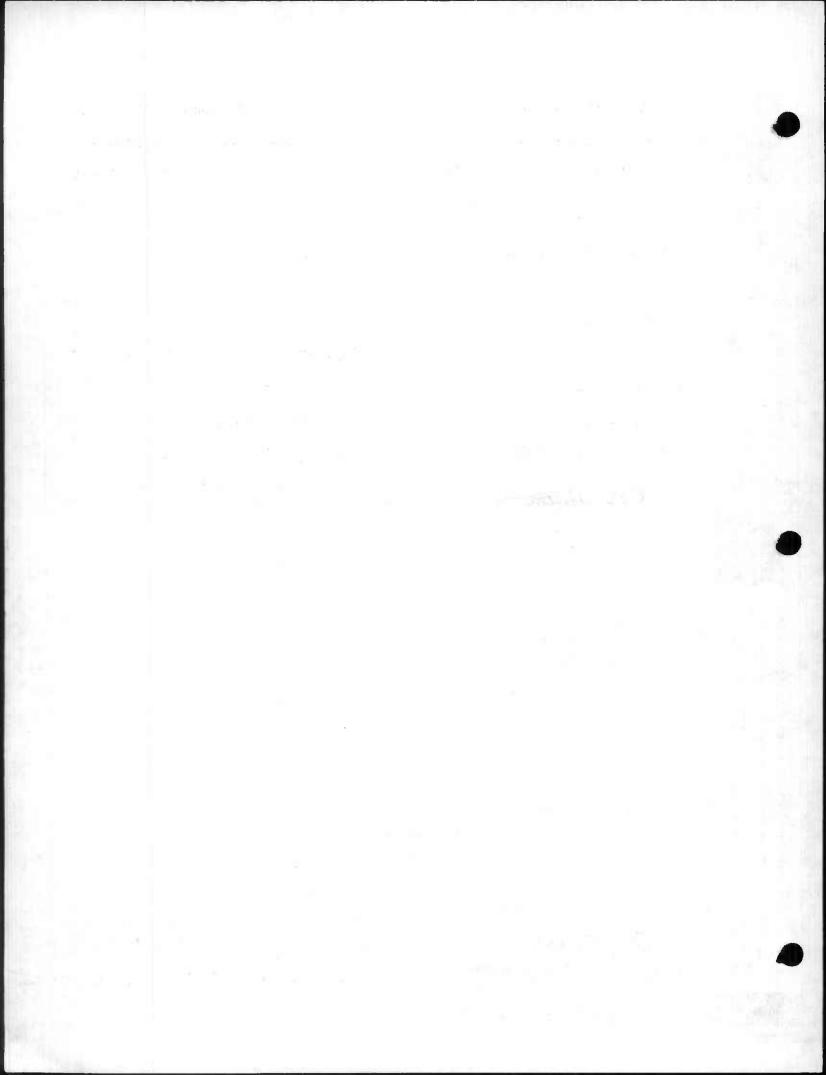
32. Registrar's Signature

oaks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

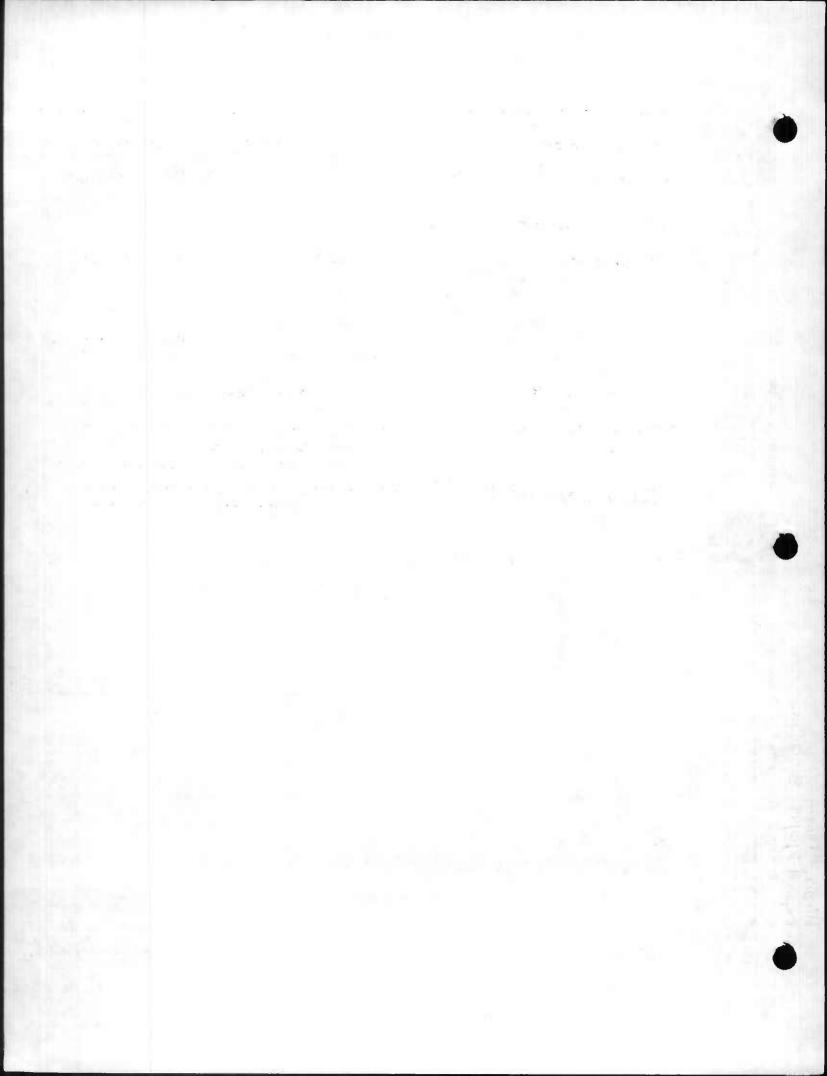
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ineral rector		401-02-5901	Sex 7. Ag 1□M 2 🛣 F	e (In yrs. lest bii 35	thday) If Under 1 Ye Yrs. Months Day		s. 8. Date of Bi (Month, D June	17, 1963	9. Birthplace (Country) Kentuc	State or Fo K Y
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	-	Rodney Minor - B	rotner		302 Annapol					
Important: if Itam 2 any Injury or other once.	1	20a. Method of Disposition 1 □XBuria1 2 □ Cremation 3 □	Removal from State		Disposition (Name of y, cremetory or other p		Date	20c. Location - C		ate
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uny Ir		21. Signature of Funeral Service Licer	isee		R. N. H	ress of Fecility lorton Co	Mortic	ians, Inc		
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0 - 0	SICI	Part II. Other significant conditions of	ontributing to death bu	t not resulting Ir	the underlying ceuse	given in Part I.	23b. Did	tobacco use contr	ibuta to the c	eusa of de
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page 2 should be datached	Completed						10	Yes 2 No	1 🗆 Yes	2□ No
page 2 should be datached	ge Completed	25. Was cese referred to medical examiner?	Hospital:				_		1 ☐ Yes	2□ No
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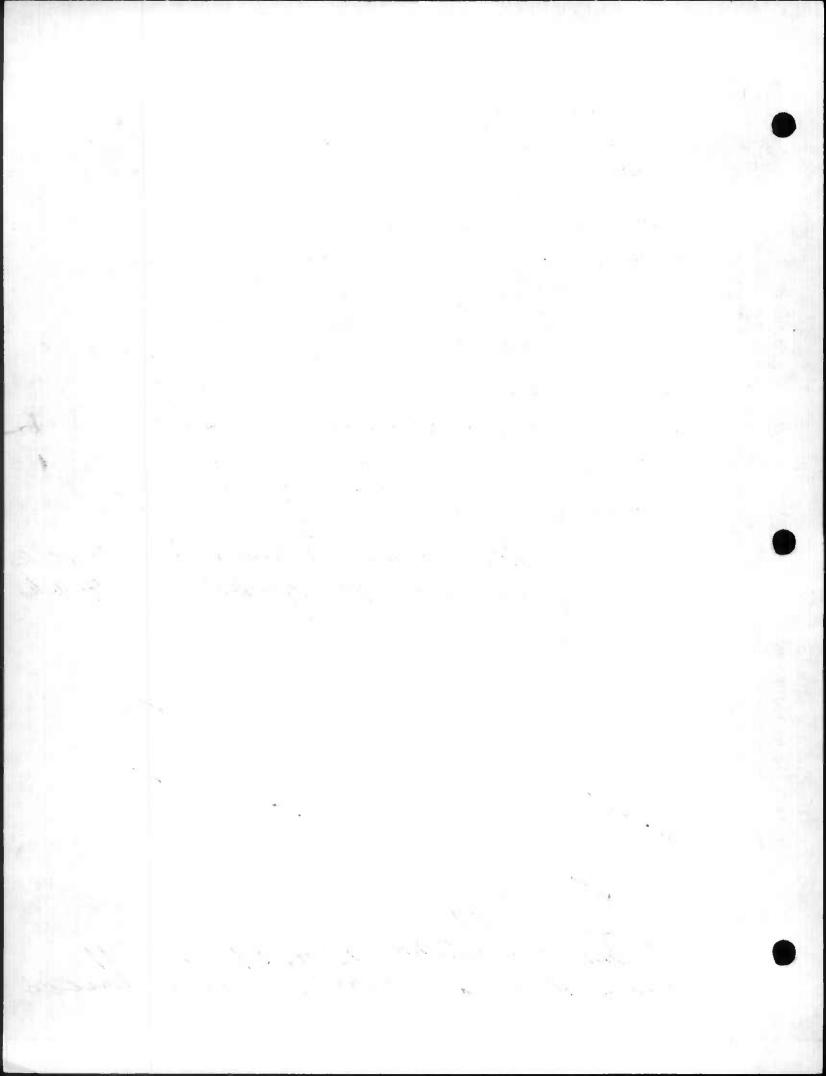
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	Physician /Medical	William Edward Miron, Jr.	February	6, 1999	8:00 AM
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	Funeral	5. Social Sacurity Number 6. Sax 7. Age (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs.	8. Data of Birth (Month, Day, Ya		rthplaca (Stata or Foraign ountry)
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tion the state of	8 m	10a. Stata 10b. County 10c. City, Town or Location			10d. Insida City Limits
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4	or 28a-f	10e. Street and Number 10f. Zip Coda	10g.	Citizen of What C	ountry?
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Baltimore, Maryland 21215-0020	penint, rages the life and whellat higher. Deportment of the life and Mental higher. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examine in all be notified at once. To Be Completed by Funeral Director	Thomas P. Miron / son 9702 Cable Drive, Kens	ington. M	arvland	20895
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	within 24 To the Fu	29b. Signatura and titla of certifiar 29c. Licansa number	29d	. Data signed (Moi	nth, Day, Year)
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		Patricia L. Tomsko, MD, 11140 Rockville Pike, #	=348 Ray	Lillo	mp mos
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Count	State Registrar	FEB 11 1999 Souls			

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

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23a. Part1. Enter the disease, or o	CK ams										
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Physician /Medical Examiner

Examine

Physician

/Medical

Examiner

Funeral

Director

r than "naturel", or items 23s or 25s-f show the Medical Examiner must be notified at

id 2 should be filed within 72 hours efter deeth with the not Mental Hygiene.
It is marked other than "naturel", or flems 23a or traumetic event, the Medical Executer must be not

Peges 1 end 2 should be fill ment of Health end Mental Hant: If Item 27 is marked oth jury or other traumatic even

permit. Pege Department of Important: If I any Injury or pace.

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

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physician end the buriel-trensit ed by the e signed by t peeu has page 2 certificete After this Director: After this in by the funerel deeth. efter

lew requires that the deeth certificate be executed

The

or Attending Physician:

Tot

Records, P.O. Box 68760,

Physician/Medicai Pert ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings eveileble prior to 24e. Wes en eutopsy performed? Completed completion of cause of deeth? 25. Wes case referred to medical examiner? Be 28. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) Church 1 ☐ Yes 25 No 2 1 Inpatient 2 ER/Outpetient 3 DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Yeer) 28d. Describe how injury occurred 28b. Time of Certification: 28c. Injury et Work? 1 Accident 5 Pending investigation 1 Yes 2 No

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

24 hours within 24 hor To the Fune completely fi

> State Registra

edical

6 Could not be determined

3 ☐ Suicide

29a. Certifier

4 Homlcide

(Check only one)

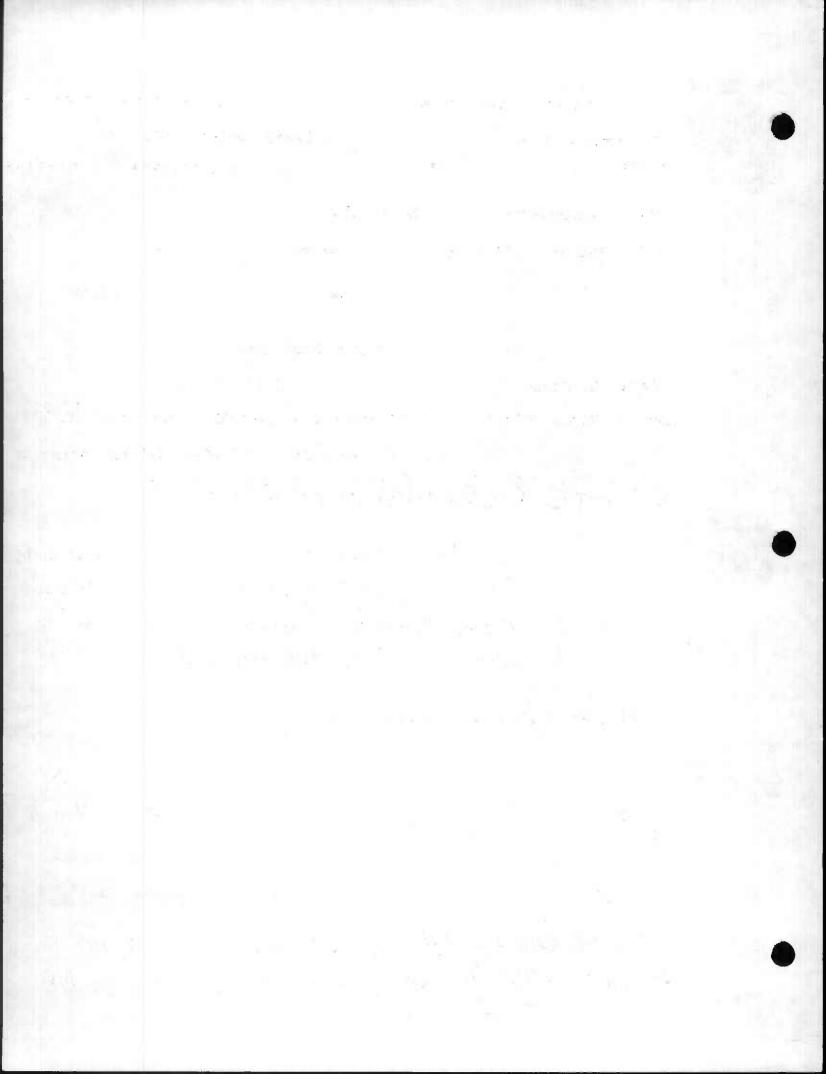
29b. Signature and tipe of certifier

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29c. License number

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

eted cause of deeth (Item 23e) (Type, Pint) Suite 200. Spring 5 32. Registrer's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Death **Physician** Clyde A. Morrison February 10, 1999 2:10 AM /Medical 4a Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 4205 Dahill Road Montgomery Wheaton If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) July 17, 1926 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys 1 X M 2 F Yrs. 72 379-24-2659 Director Michigan Usual Residence of Decedent death with the Meryland 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahow the Medical Examinar must be notified at 1 ☐ Yes 2 ☒ No Director Montgomery Wheaton 10e Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4205 Dahill Road 20906 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, 11 Merital Status Bleck, White, etc. filed within 72 hours after 1 Tyes 2 No
If Yes, Give
Yeer or Detes: 1945-46 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: by 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Etementery/Secondary (0-12) College (1-4or 5+) 5+ Mathematics permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If them 27 is marked othe any Injury or other traumatic avant, phose. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Dougal Morrison Jenni Manning 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzanne Morrison / Wife 4205 Dahill Road, Wheaton, MD 20906 20b. Plece of Disposition (Neme of cametery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Metropolitan Crematory 2/11/99 Alexandria, VA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Francis J. Collins Funeral Home, Inc. 500 Uinversity, Blvd.West Silver Spring, MD 20901 23e. Perf. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediete Ceuse (Final diseese or condition resulting in deeth) /Medical Widespread Metastatic Disease 8 months Examiner Due to (or as e consequença of): Examiner Carcinoma Prostate 9 years the death certificate be executed physician and s the burief-trans Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in deeth) Lest Due to (or es e consequença of): Box 68760. Physiclan/Medical Due to (or es e consequenca of): 88 980 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 ☐ Unknown þ been sig 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed egaq 2 No 1 Yes 1 ☐ Yes 2 ☐ No certificate Be 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) 2 Hospitel: Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year)

P.0. Records, of Vital Division

this After Hospital or Attanding death. Director: after To the Hospital of within 24 hours a To the Funeral D completely filled

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) (Check only one) end menner steted. 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number D02338 February 10, 1999

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and eddless of person who completed cause of deeth (Item 23a) (Type, Print)

Richard P. Delaney 9801 Georgia Avenue, Silver spring, MD 20902

State Registrar

Medical Certification:

1 Netural

2 Accident

3 Suicide

29e. Certifier

4 Homicide

31. Dete filed (Month, Day, Year)

FEB 1 2 1999

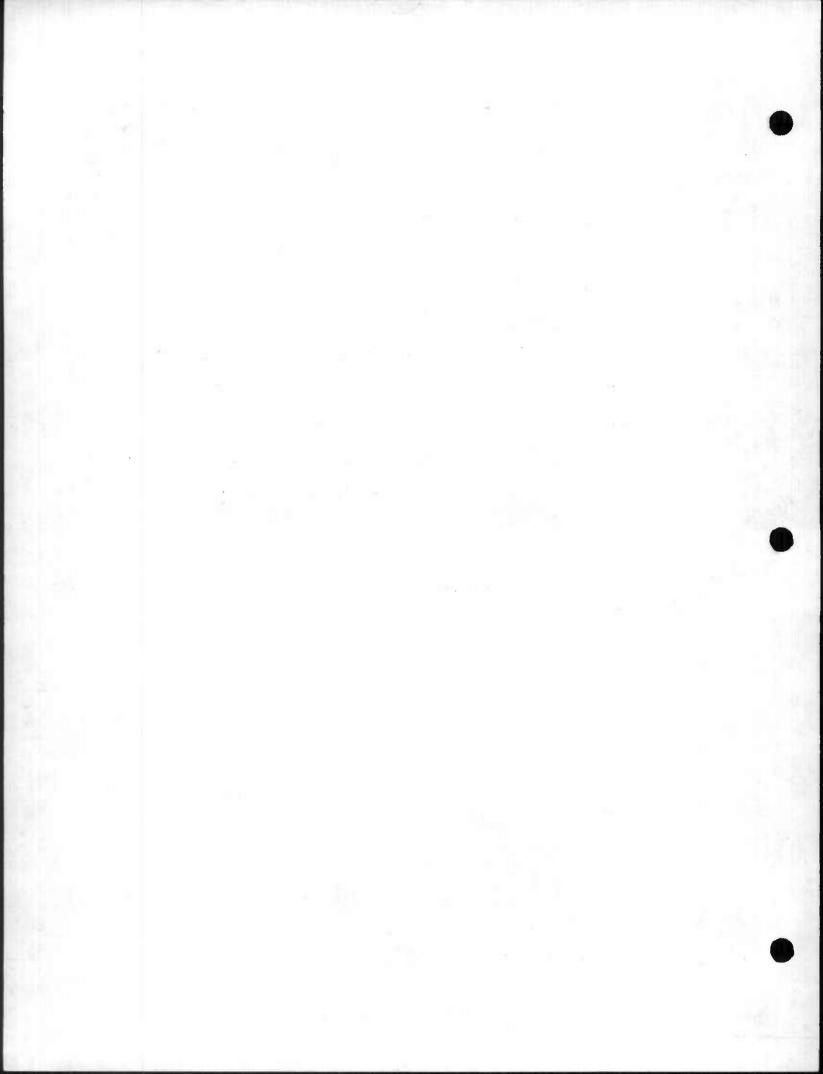
5 Pending investigation

6 Could not be determined

32. Pegistrar's Signeture

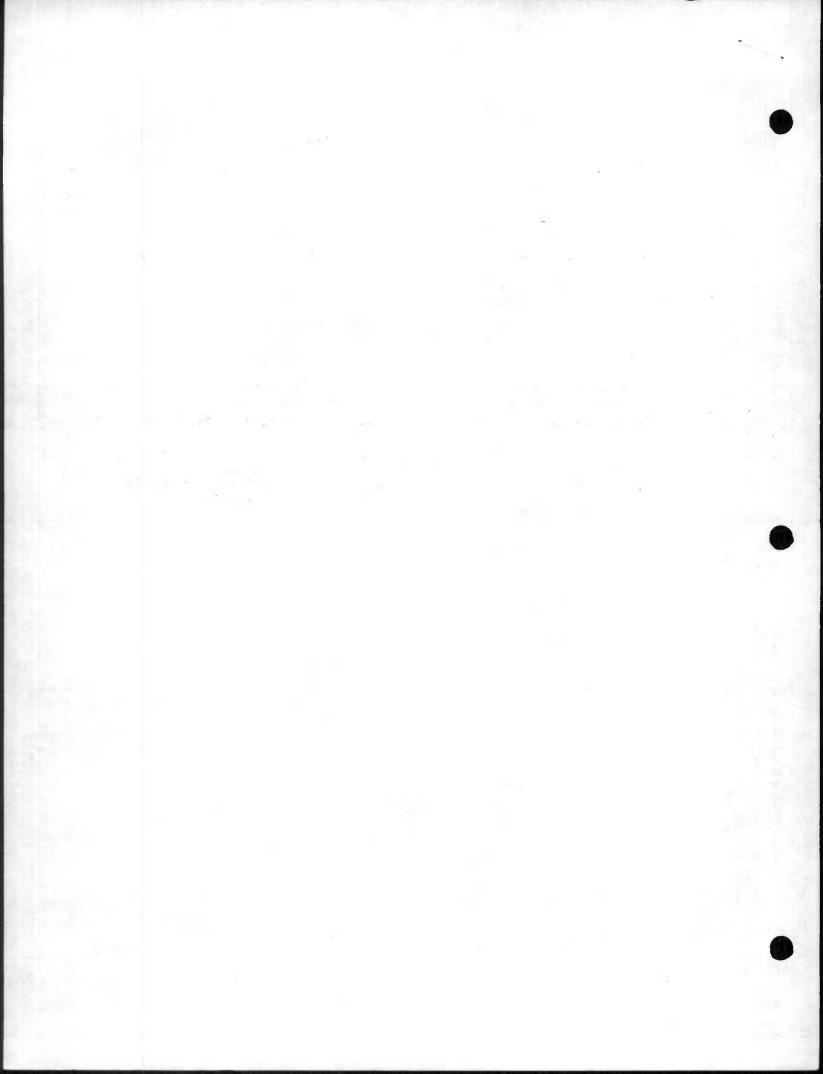
28b. Time of

Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)



_	1. Decedent's Name (I	First, Middla, Las	it)		Certific	cate of	Death	2. Date of D	Reg. No. 9	0.5	3. Time of Death
Physician	Md I day of	C. Mor	ri con					Month Februa:	ry 3, 199	Year	10:58 PM
/Medical	4a Facility Name (If no			1			4b. City. Town. o	r Location of Dea	-		10.30 TH
Examiner	Aspenwood						ilver Sp			omery	
	5. Social Security Num			ge (In yrs. last	birthday) If U	Inder 1 Year	If Under 24 H	rs. 8. Date of B	irth FIOTICE	, ,	e (Stata or Foreign
uneral irector	169-01-41 Usuel Residence of De	68	□ M 203 F	90	Yrs. Moi	nths Days	Hours Mi	8. Date of B Month, D Feb. 9	1908 E	Country	lvania
or state		0b. County		10c. City, To	own or Location	1				10d.	Inside City Limits
Examiner must be notified at by Funeral Director	MD	Montgo	merv	Si1	lver Sp	ring					1 ☐ Yes 2 🛣 No
Director	10e. Street and Number					f. Zip Code			10g. Citizen of W	het Country	?
0	14400 Hom	ecrest 1	Road, Apt	44		2	0906		US	SA	
Funeral	11. Meritel Status		12. Was Decedent	Ever in U.S.	13. Was 0			(Specify Yes or Narto Rican, etc.)	o- 14. Race	- American	
by Fu	1 ☐ Never Merried 3 🖾 Widowed 4 [Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	No		es 2 No	Specify:	eno Hican, etc.)	Specify.	k, White, etc	hite
Completed	15	. Decedent's Ed	ucation	10	6a. Decedent's	Usuel Occup	pation		16b. Kind of Bu	siness/Indus	itry
pie	(Specify Elementery/Seconds	only highest gree	da complated) Coilege (1-4or l	54)	(Giva kind o lifa, DO N	of work done OT use retire	during most of w	rorking	Washingt	on Ai	r
EO	10	11) (0 12)	Conego (1-40)	017	Secr	etary			_	ake C	
Bec	17. Father's Name (Fir	st, Middle, Last)					18. Mother's N	ame (First, Middle	e, Meiden Sumem	a)	
To	William H	. Potti	nger					L. Ludw:			
	19a, informant's Name	9/Relationship (7	ype, Print)	1	9b. Mailing Ad	dress (Street	and Number or	Rural Routa Numi	ber, City or Town,	Stata, Zip Co	ode) 20906
	Elsie M.	Morrison	n (sister					Apt. 44	, Silver		
	20a. Method of Dispos		Removel from State	20b. Place cama	of Disposition	(Name of or other pla	ce)	Date	20c. Location -	City or Town	, State
	4 Donation 5				dview C	emeter	cy	2/8/99	North Ve	rsaill	les, PA
	21. Signature of Funer	al Service Lican	500		Home	, Inc.	ss of Facility I 500 Ur ing, MD	rancis niversity 20901	J. Colling Blvd. W	s Fundest	eral
	23a. Plat1. Enter the shock, or heart fa	diseese, or comp	olicetions that caused	d the death. D					errest,	. A	pproximete
n	shock, or heart to	ailure. List only o	one cause on each li	ine.						in	tervai Between nset end Death
al .	Immediate Cause (Fin	al	Za	ANIT	FIDAL					1 21	Veeks.
r	disease or condition resulting in death)		a		e consequence	a of):				1	veers.
ě				Due to (or as	e consequence	e orj.				1	
Examiner	Sequentially list condit	tions,	b	Due to (or as	a consequence	a of):					
a E	Sequentially list condit if any, leading to imme cause. Enter Underlyi Cause (Disease or inju-	ng ury	c								
edicai	thet initiated events resulting in death) Las			Due to (or as	a consequence	a of):				ì	
			d							1	
ciar										- !	
Physician/M	Part II. Other algnifica	n1 conditiona co	entributing to death b	ut not resulting	g in the underly	ring cause giv	ven in Part I.		-		ne cause of death?
								11	Yaa 2 X No	3 Probab	bly 4 Unknown
Completed by									s en autopsy iormed?	availa	autopsy findings able prior to eletion of cause
P P									ba	of dea	
					100			1L	Yes 2 No	1 U Y	'es 2□ No
Be	25. Was case referred examiner?	+	Hospital:			Ott	or:	eath (Check only			
10	1 Yes 2 No		1 ☐ inpatie		Outpatient 30	L DOA	4 LI Nursing		how injury occurr		
lon	1 Natural	Pending	(Month, Da	y Year)	Injury	28c. Inju	rk? Yes 2□No	Zod. Describe	rilow injury occurr	60	
Ca	2' Accident 3 Sulcide	investigation	29a Place of Ini	iuns - At homo			165 2 100	28f Location	(Street and Numb	er or Rural B	Pouts Number
Certification:	4 Homicide	determined	28e. Placa of Inj building, et	c. (Specify)	, term, street, to	ictory, office			own, State)	er or nurar n	obia rumber,
edical Co	(Check only 2	Certifying Phy Medical Exam	raician: To the best of the basis of	f examination	ige, death occu	irred et the til ation, in my c	me, date and pla ppinion, death oc	ce, and due to the	e cause(s) and ma , dete end place, e	nner as state	ed. le ceuse(s)
Medical Ce	one)	of antifier	and manner sta	ated.		29c. Licens	a number		20d Date signer	Alonth Do	ve Veerl
-	29b. Signature and title	of Continer	10 10	111		7 3	707		29d. Date signed		1
	1 verce	WNO	my	M		23	, , , ,		TEBRUA	HRY 4	,1777
	30 Name and address KOBERT &	of person who o	ompleted cause of d	leath (Item 23)	a) (Type, Print)	ce Fh.	lip Dr	#312 6	DLAVEY,	aw	20832
State	31. Date filed (Month,		32 Registr	er's Signeture	0	,					
gistrar	FEB	n 9 1999	Beer	رسم	19 1	20.1	,				

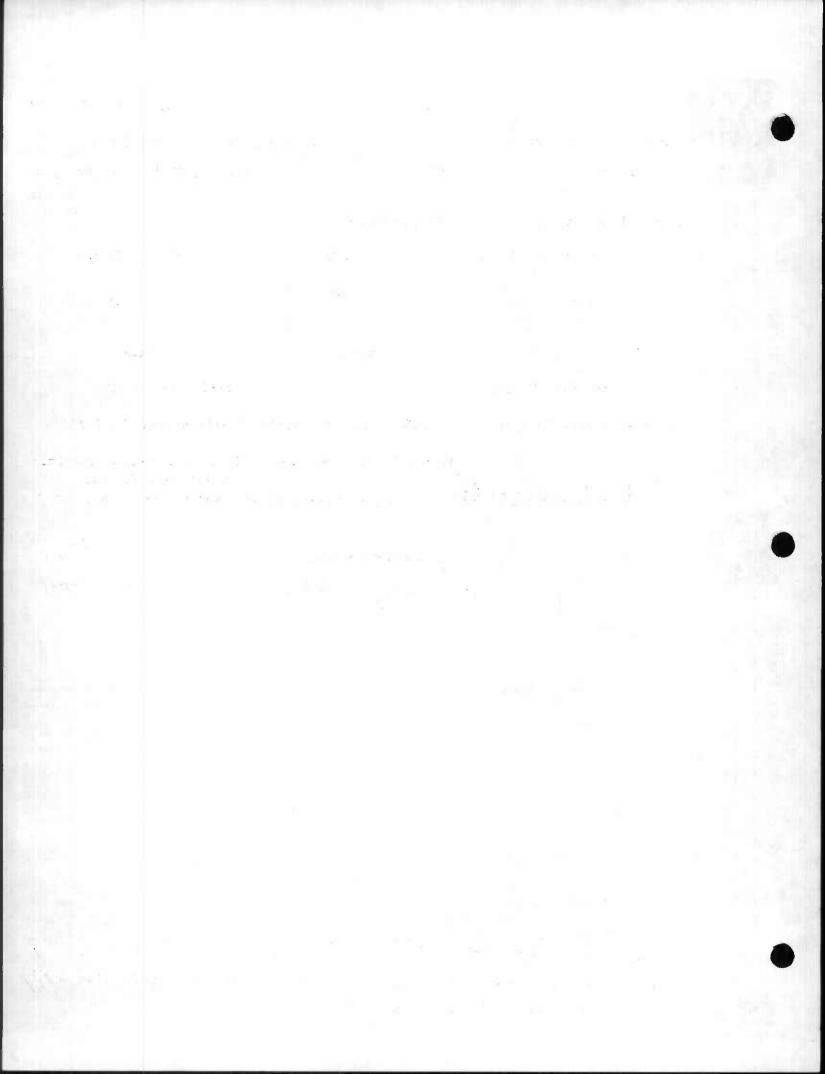
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

					Cert	ificate o	of Death		leg. No.	4.57.6.
Physicia	an	Decedent's Nama (First, Middle, I	.ast)					2. Date of Dea Month	Day	3. Time of Death
/Medic		Gladys	Laws	Mose	1ey			Februar	-	999 3:56 PM
Examin	er	4a Facility Name (If not institution, g	ive street and number))			4b. City, Town, or I	ocation of Daath	4c. County	of Death
		Wilson Health C	are Center				Gaithers If Under 24 Hrs.	burg		tgomery
Funeral		Social Security Number 8.	Sex 7. A(st birthday)	If Under 1 V Months Da		(Month, Day	Year)	Birthplaca (Stata or Foraign Country)
Director		220-28-6004	ILIM ZEIF	93	Yrs.	AVOIDZZE III. ZO	320	June 2,	1905 W	ashington, D.C
P .		Usual Residence of Decedent 10a. State 10b. County		100 City	Town or Loc	ation				10d. Inside City Limits
anyta show		Toa. State Too. County		Toc. City,	, TOWIT OF LOC	ation				1 ☑ Yes 2 ☐ No
M 98 4	cto	Maryland Montgo	nery	Ga	ithers					
or 2	i i	10e. Street and Number				10f. Zip Co	de		log. Citizen of W	hat Country?
23a	0	333 Russell Ave	nue, # 418				877			States
TILL K. I.K. 13-0020 De filed within 72 hours effer death with the Maryland be filed within 72 hours effer death with the Maryland other than "natural", or items 23s or 28s-f show do other than "natural", or items 23s or 28s-f show event, its Modified Examinet must be nother at	Funeral Director	11. Marital Status	12. Was Decedant Armed Forces?	?	5. 13. W	as Decedent Yas, specify	of Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yes or No- o Rican, atc.)	14. Race Black	- American Indian, k, White, etc.
of of the control of		1 Never Marriad 2 Married	1 ☐ Yas 2 ☐ If Yes, Give	No			No Specify:		Specify:	
ours Feet	d by	3 Widowed 4 Divorced	Yaar or Datas:							White
72 t	Completed	15. Decedent's (Specify only highest of	Education rade completed)		(Give k	int's Usual Oi ind of work d	one during most of wor	king	16b. Kind of Bu	siness/Industry
d within 72 hours of giona. The Modified Even	dr	Elementary/Secondary (0-12)	College (1-4or	5+)		O NOT use re				
e filed within ei Hygiena.	3	6			Но	usewif		(F) 1 4 4 1 4 H	Hot	
d deth	Be	17. Fathar's Nama (First, Middla, La	st)				18. Mother's Nan	ne (First, Middle,	Maiden Sumam	θ)
Mal yland 2 should be file th end Mentei Hy 7 is marked oth traumatic event	2	Ira Eug	ene Laws					Carrie	Mae I	Weller
2 sh end is m		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailing	Address (St	reet and Number or Ru	ral Route Numbe	r, City or Town,	State, Zip Code)
ite, Mal yle		Dorothy M. Bangs	/Daughter		9860 I	ocksi	le Terrace,			
of Her		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3	□ Barroval from State	00	aca of Dispos metery, cremi	ition (Name o atory or other	place)	Date	20c. Location -	City or Town, State
caltimore, mit. Peges 1 er partment of Hea portant: if item; y injury or othe		4 Donation 5 Other (Spec			ropoli	tan Cr	ematory	2/6/99	Alexand:	ria, Virginia
permit. Peges 1 en Department of Healt Important: if item 2' any injury or other ance.		21. Signature of Funeral Service Lic	ansae	1	-		ddress of Facility		Funera	
Deparimon any ir		MI I	al lul	VL	10	T T	na a Danie D			
		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause	d the death.	. Do not ente	the mode of	dylng, such as cardiac	or respiratory ar	nersbur rest,	g, MD. 20877 Approximate
Dhysisian		shock, or heart failure. List on	ly one cause on each I	ine.						Interval Between Onsat and Death
Physician /Medical		Immediate Cause (Final					,			dans
Examiner		disease or condition rasulting in death)	a	P		Mon				days
Cres Con	ě			Due to/(or	as a consequ	ence of):	Elwsis			16 000 0
nsit nsit	듣		b		ronal		Pansis			years
y xacu and al-tra	ха	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	,	Due to (or	as a consequ	ence or):				
g physician and	edical Examiner	Cause (Disease or injury that initiated events	c							
ficete be ex physician	9	resulting in death) Last		Due to (or	as a consequ	ence of):				
	-	A standards to	d							
daath cer a attendin	lan									
that the danged by the and datached is	Physician/N	Part II. Other significant conditions	contributing to death t	out not resu	lting in the un	derlying caus	e given in Part i.	23b. Dld t		tribute to the causa of death?
Ad by								10	res 20 No	3 Probably 4 Unknown
0 5 5 C	by							040 11/00		24b. Were autopsy findings
v require been si should l	Completed								an autopsy med?	available prior to completion of cause
2 s S	du			-						of death?
The it	5							101	es 2 No	1 ☐ Yes 2 ☐ No
sicien: The certificate	Be	25. Was case referred to medical examiner?					26. Place of Dea	ath (Check only o	ne)	
Physician: this certific ral director,	70	1 ☐ Yas 2 ☐ No	Hospital: 1 Inpati	ient 2 🗆 E	ER/Outpatient	3□ DOA	Other: Nursing H	loma 5□ Resid	lenca 6 Othe	er (Specify)
g Phys er this seral di		27. Manner of Death	28a. Date of Inju	ury av Year)	28b. Time of Injury	28c.	Injury at Work?	28d. Describe h	ow Injury occurr	ed
SICI tending I leeth. tor: After the funer	atio	1 Natural 5 ☐ Pending investigat		ay roar/	Hijary	М	1 ☐ Yes 2 ☐ No			
ON Attending after deeth. Director: After d in by the fune	Certification:	3 Suicide 6 Could not determine	d 28a. Place of in			et, factory, of	lica	28f. Location (S City or Tow	Street and Numb	er or Rural Routa Number,
d of g	ert	4 D Homicide	building, e	tc. (Specify,	,			City of You	ni, Siale)	
spita nours neral		29a. Certifier 1 Dertifying I	Physician: To the best	of my know	vledge, death	occurred at th	ne time, date and place	, and due to the	ause(s) and ma	nner as stated.
P Ho P Fu	edicai	(Check only 2 Medical Ex	aminer: On the basis of and manner si		on and/or inve	estigation, in	ny opinion, death occu	rred at the time,	date and placa, a	and due to the cause(s)
To the Hospital or Attending is within 24 hours after deeling. Yo the Funeral Director: After completaly filled in by the funer	Me	29b. Signature and title of cartifier		1		29c. Li	cense number		29d. Date signed	(Month, Day, Yaar)
F 5 F 0		100	n. 0	1	a.nu	-	D192911		Februa	m/ 51999
6		20 Name and discount of the control of	o completed and	don't "	220) (5:00	eint)	11217		, -,	12/11/
		30. Name and address of person wh	nELMICK	C /			ME.	GAITH	edsnis	in 5,1989 IC Md 20179
		31. Date filed (Month, Day, Year)		rar's Signat		BELL	//	30,,,,,,		1
Stat Registra	_	FEB 0.9 1	999		6	1				

DHMH 16 Rav 6/95



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		C	ertificate	or Dea	11//	1	Reg. No.		
1. Decedant's Nama (First, Middla, L	ast)					2. Date of Dea	ath Dey	Yeer	3. Tima of Death
Gwendolyn D. Mu	rnhv					Februar		99	1:15AM
le Fecility Neme (If not institution, g				4b. Cit	y, Town, or L	ocation of Deeth			1.13.111
Shady Grove Adv	ontict Nurs	ing Homo		Por	ckvill	^	Monto		
		(In yrs. last birthd	ey) If Undar 1 \	aar If U	nder 24 Hrs.	8. Date of Birt (Month, De	Monte	9. Birthp	lace (Stata or Forai
218-16-1502	1□ M 2 F	76 Yrs	. Months D	ays Ho	urs Min.	July 28	y, Yaar)	Coun	nessee
Jsual Rasidance of Decedant						Journ 20	, 1,22	10111	nebbee
10e. State 10b. County		10c. City, Town or	Location					1	0d. Insida City Limit
Maryland Montgon	nerv	Rockvil	lle						1⊠Yas 2□N
I Oe. Street and Number			10f. Zip Co	da			10g. Citizan of V	What Coun	ntry?
195 Leland Street				20850			United	Stat	es
11. Maritel Status	12. Was Dacedant E	var in U,S. 1	3. Wes Decedent If Yes, specify	of Hispeni	ic Origin? (Sp	pecify Yes or No-	- 14. Rac	e - Amaric	
1 ☐ Navar Married 2 ☐ Married	Armed Forces? 1 ☐ Yas 2 ☑ No				xicen, Puarto	Rican, atc.)	Blad	ck, White,	etc.
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yaar or Datas:		1 □ Yas 2 🛭	No Spe	ecify:		Specify	Whi	ite
15. Decedant's f	Educetion	16a. De	cedant's Usual C	ccupation			16b. Kind of Br	usinass/Inc	dustry
(Spacify only highest g	rada complatad)	(G	iva kind of work of a. DO NOT usa r	ona dunna	most of work	king			
Elemantary/Secondary (0-12)	Collaga (1-4or 5+	7	Homemak	er			Own 1	Home	
17. Fathar's Name (First, Middla, Las	st)				Mothar's Nam	na (First, Middla,			
Jesse Boyd Floyd				G	retche	n Lanie	r		
19a. tnformant's Name/Ralationship	(Type, Print)	19b. M	ailing Addrass (S					Stata, Zip	Code)
Patricia A. Perry			Leland						
20a. Method of Disposition	man, baugille		· · · · · · · · · · · · · · · · · · ·				20c. Location -		
1 ☑ Burial 2 ☐ Cramation 3			sposition (Nama cramatory or otha			10, 1999	Silver	Sprin	
4 Donation 5 Other (Spec	iny)	Gare of	Heaven	Leme	PTV		Marylan	ld	17.
Od Cinnatura of Francisco	anna d				-			. 33	7 77
21. Signatura of Funaral Salvice Lio	onsep 1	1	22. Nama and A	ddrass of F	ecilityRob	ert A.	Pumphre	y Fun	eral Home
· Vitie	the -	M01126	22. Nama and A Rockvill Rockvill	e, Ine, Ma	ecilityRob c., 30 ryland	0 West 1 20850-	Pumphrey Montgome 2805	y Fun ery A	eral Home
21. Signatura of Funaral Service Lice 23a. Part 1. Emer the disease, or conshock, or heart failura. List or	the -	M01126	22. Nama and A Rockvill Rockvill	e, Ine, Ma	ecilityRob c., 30 ryland	0 West 1 20850-	Pumphrey Montgome 2805	y Fun ery A	Approximeta Intarval Batween
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30. Name end eddress of person who completed causa of deeth (Item 23a) (Type, Print) Sunita Hanjura, M.D.

809 Veirs Mill Road, Rockville, Maryland 20851

29c. Licansa number D43272 29d. Data signed (Month, Day, Year)

February 8, 1999

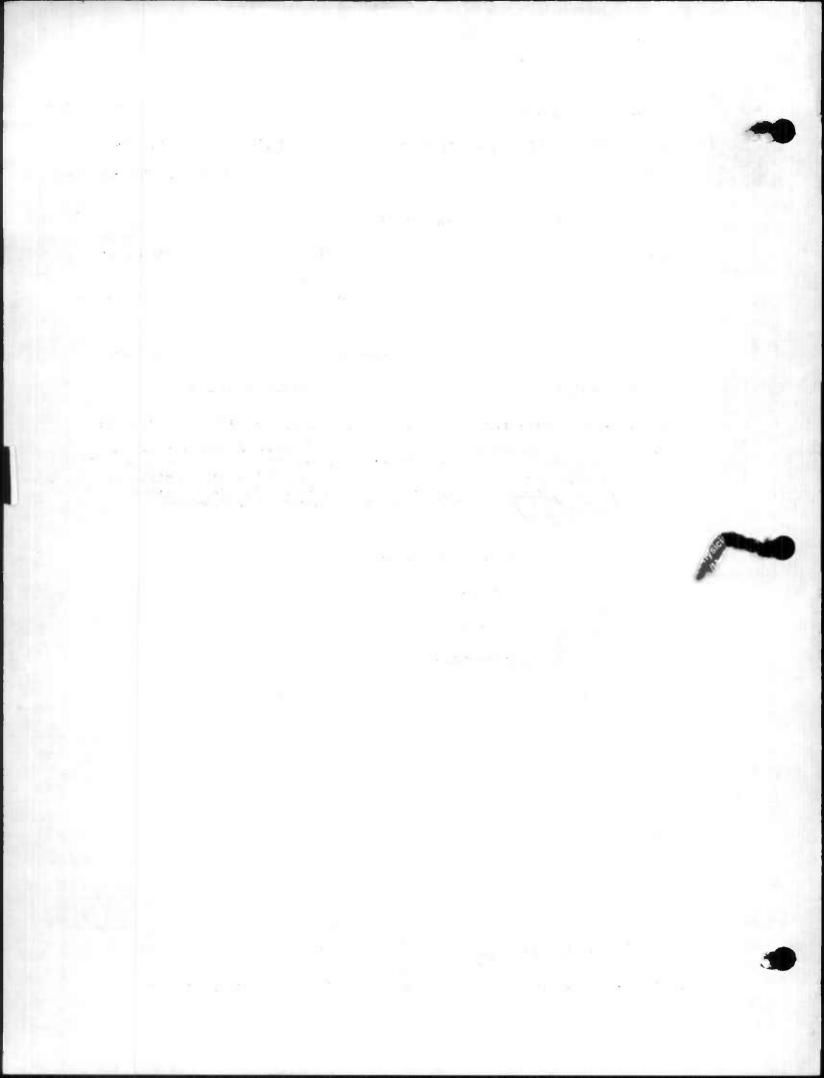
State Registrar

Medical

31. Data filad (Month, Day, Yeer) FEB 0 9 1999

29b. Signatura and titla of certifiar

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. amend item 18 per infor. G784 6/28/00 yg Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Month Vaar WILLIS S. MYERS 3, 1999 FEBRUARY 11:26 P.M. /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Undar 1 Yaar | If Undar 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign **Funeral** 1□XM 2□ F Months Yrs. Director 466-34-3359 72 MISSOURI Usual Rasidanca ot Dacedant the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits ? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1□ Yas XXINo Director MARYLAND MONTGOMERY POTOMAC 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 8913 LIBERTY LANE 20854 UNITED STATES Funeral 12. Was Decedant Evar In U,S. Armed Forcas? 14. Race - Amarican Indian, Black, Whita, atc. Was Dacedant of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuben, Maxican, Puarto Rican, atc.) e filed within 72 hours after of Hygiene.
other than "natural", or iter TY□ Yas 2 □ No If Yas, Giva Yaar or Dates: 1 Navar Marriad 2 Narriad 1 ☐ Yas 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind ot Businass/Industry Collega (1-4or 5+) Elamantary/Sacondary (0-12) 12 PHYSICIAN 5+ HEALTH CARE permit. Pages 1 and 2 should be file Deportment of Heelth and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic event, once. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be MARVIN B.F. MYERS HAZEL BOONE Hazel Boone Smith 2 19a. Intormant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straet and Numbar or Rural Routa Number, City or Town, Stata, Zip Code) JEAN MYERS - WIFE 8913 LIBERTY LANE, POTOMAC, MARYLAND 20854 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod ot Disposition Data 20c. Location - City or Town, Stata 1 XBurial 2 ☐ Cramation 3 ☐ Ramoval trom State 4 ☐ Donațion 5 ☐ Otae: (Spacify) ARLINGTON NATIONAL CEMETERY 2-10-99 ARLINGTON, VIRGINIA of Funeral Service Lia 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE., SILVER SPRING, MD 20904 204. Part1. Entar tha disaasa, or complications that causad th shock, or haart tailure. List only ona causa on aach lina. complications that caused the death. Do not only the mode of dying, such as cardiac or respiratory arrest, Approximata Intarval Batween Onset and Daath immediate Ceusa (Final

Physician /Medical Examiner

Baltimore, Maryland 21215-0020

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funeral

Box 68760

Records, P.O.

Division of Vital or Attending Physician:

90

Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disease or Injury that initiated avants rasulting in daath) Last

disaasa or condition rasulting in daath)

Examiner Physician/Medical by Completed Be 25. Was casa retarrad to medical Certification:

Dua to (or as a consequance of):

Dua to (or as a consequence of):

Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24e. Was en eutopsy parformad?

24b. Wera eutopsy findings available prior to completion ot cause of death?

1 Yas

26. Placa ot Daath (Check only ona)

1 ☐ Yas 2☐ No

	axaminari	
	1 Tyes	20 No
07	Managarat	Death

5 Panding Invastigation 6 ☐ Could not ba daterminad 28a. Data ot Injury (Month, Day Year)

12 Inpatiant 2 ER/Outpatient 3 DOA 28b. Tima of

28a. Place of Injury - At homa, farm, street, tactory, offica building, atc. (Specify)

Other: 4 Nursing Homa 5 Rasidanca 8 Othar (Specify) 28c. Injury at Work?

1 ☐ Yas 2 ☐ No

28d. Dascribe how injury occurred

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifian (Check only one)

Medical

1 □Natural 2 □ Accidant

3 Suicida

4 Homicide

12 Cartifying Phyalcien: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as steled.

2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end manner stated. 29d. Data signad (Month, Day, Year)

29b. Signatura and titla of cartifiar

29c. Licansa numbar D38262

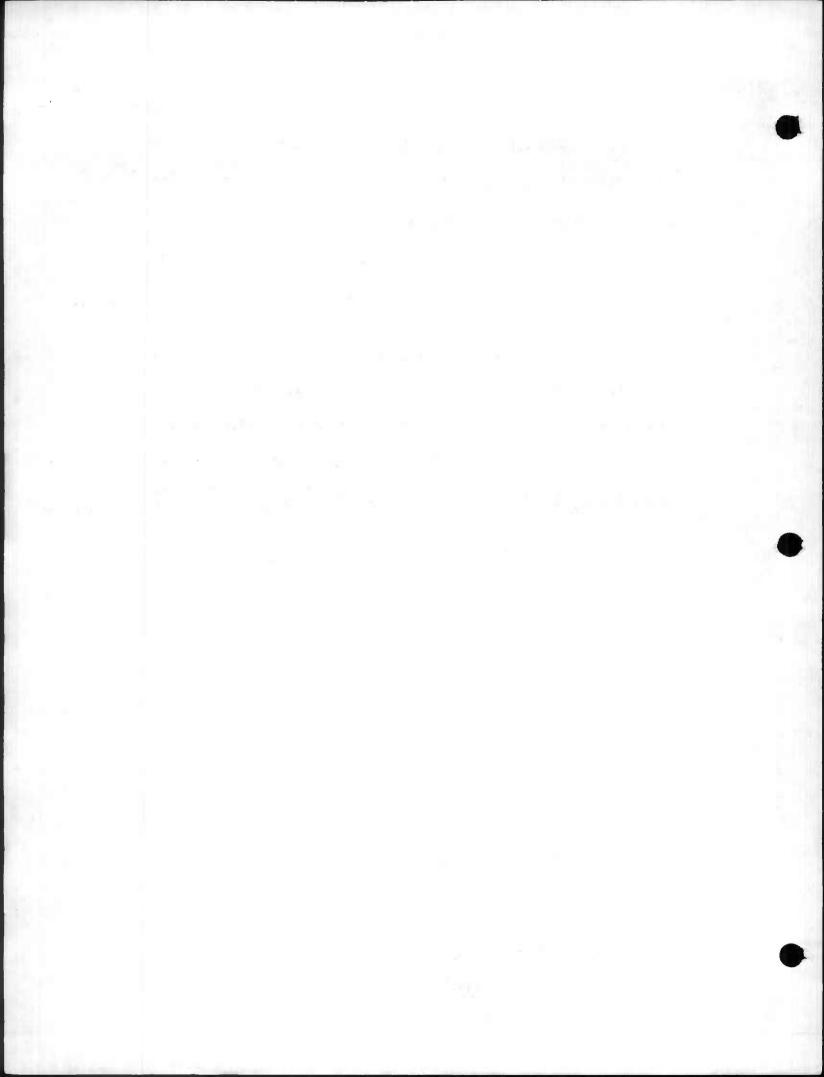
30. Neme end addrass of person who completed causa ot death (Itam 23a) (Type, Print)

1999

18111 Prince Philip Dr Sute 212 O'ney mp 20832 Dr MendhiralTa

State Registrar

32. Registrar's Signatura



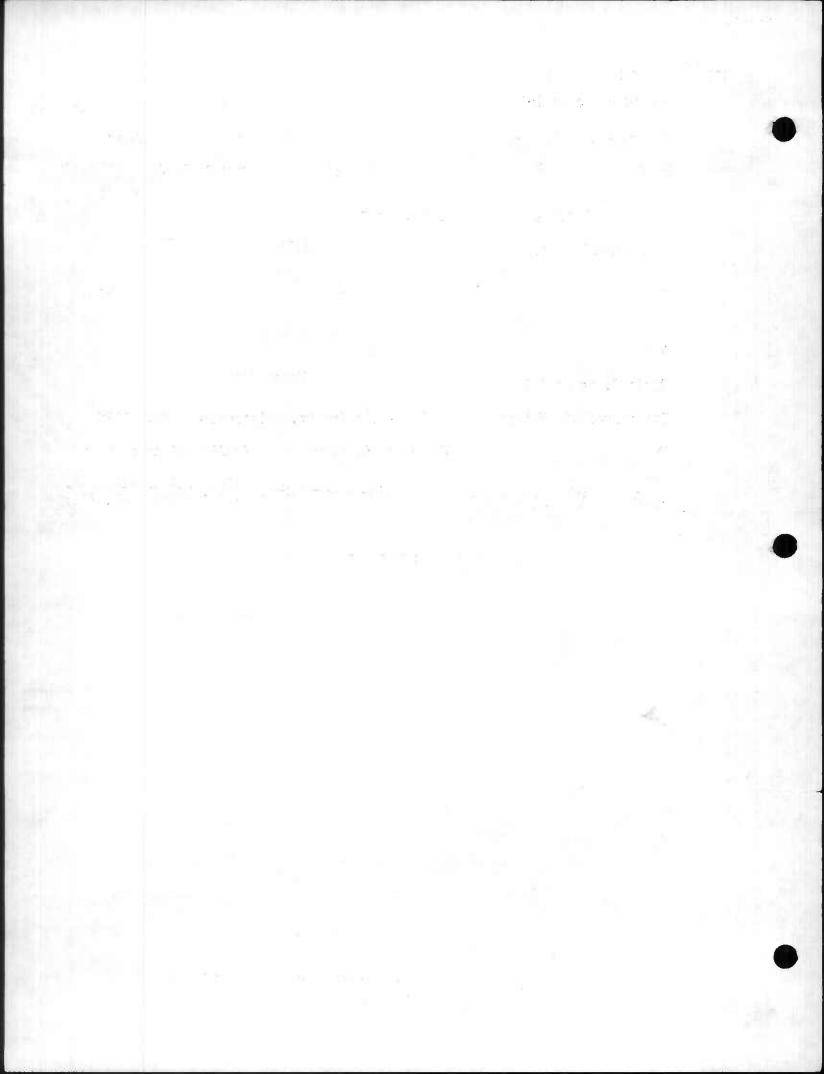
State of Maryland / Department of Health and Mental Hygienen DAVID R. McDANIEL ITEMS: #23 PART Certificate of Death #23 PART I. 27 PER MEO G769 3-23-99 WR. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** David R. Mc Daniel 13, 1999 FEB. 8:12 AM · /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTHWEST HOSPITAL E.R. RANDALLSTOWN BALTIMORE If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Mov 20 1998 7. Age (In yrs. last birthday) Funeral None 1DXM 2DF Director Usual Residence of Decedent y 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Reisterstown Baltimore 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code other than "natural", or items 23s or vent, the Medical Examiner must be r 21136 26 Brookshire Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 ☐ Married Specify: White Maryland 21215-0020 1 Ves 2 № No Specify: à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) None (0-12) College (1-4or 5+) None traumatic event. 18 Mother's Name (First, Middle, Maiden Surname) Tracy Smith 17. Father's Name (First, Middle, Last) d 2 should be fill h and Mental H I is marked off David J. Mc Daniel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 at Department of Health and Important: if Item 27 is in any Injury or other traun once. Tracy Brodski Mother 26 Brookshire Dr. Reisterstown, MD. 21136 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Al 1"Saints" Cemetery 2/23/99 Reisterstown, md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 11824 Reisterstown Rd. Eline Funeral Home Reisterstown, MD. 21136 ano Line 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical SUDDEN INFANT DEATH SYNDROME Examiner Due to (or as a consequence of): Examiner burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician Box 68760 Physician/Medical 120 Due to (or as a consequence of): 88 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 8 6 1 Tes 2 No 3 Probably distinknown peudis Division of Vital Records, ğ 24b. Were autopsy findings available prior to 24a. Was an autopsy Completed **DBGB 2** certificate has ANT Yes 2 No Wes 2□No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 3C FVOurpatient 3C DOA Other: 4□ Nursing Home 5□ Residence 6 □ Other (Specify) 10 XX Yes 2[] No mia 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 1 DNatural Attending 5 Pending death. t ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Funeral D Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

WM Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical To the F 29b. Signature and title of gertifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E FEB. 14, 1999 Dermit Chut no ted cause of death (Rem 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 30. Name and address of person who corre hute no Dennis 31, Date filed (Month, Day, Year) 32/Registrar's Signature State

State Registrar FEB 2 4 1999

Fregistrar's Signature B. Sparits



State of Maryland / Department of Health and Mental Hygiene 0

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altimore, Maryland 21215-0020	mit. Pages 1 end 2 should be liled within 72 hours efter deeth with the Maryland artment of Heath and Martial Horisons.	Portant: If Item 27 is marked other than "natural", or Items 23s or 28s-1 show / Injury or other traumatic event, Its Medical Examinar must be not that as a second of the contract of the con

Physicia /Medic Examin

To the Hospital or Attanding Physician: The lew requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit Division of Vital Records, P.O. Box 68760,

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JAMES H.	MERRILL					DRUCII	LLA		н	JMMEL	L
19e. Informant's Name/Relationsh	hip (Type, Print)		19b. N	Mailing Addra	iss (Street	t and Number or	Rural Routa Nun	ber, C	ity or Town,	State, Zip	Code)
CATHERINE MERI	RILL - WI			RIVER		L ROAD	OAKLAN	D, 1	MD 215	550	
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		State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 99 05468												
	Physician /Medical Examiner Funeral Director	Decedent's Name (First, Middle, Last)								2. Dete of Death Month Day Yee			3. Time of Death	
		ELOGEANNE	E DAR	DEN	MOO	DRE				FEBRUARY 10, 19			5:50 PM	
1		4e Fecility Neme (f.	give street and n	nd number) 4b. Cit			4b. City, Town, or L	wn, or Location of Deeth		4c. County of Death				
		DENNETT H	ROAD MAN	OR NURS	ING HON	1E			OAKLAND		GARR	RETT		
,		5. Social Security N 215-20-51	.Sex 1 □ M 2 X □ F				Under 1 Yeer If Under 24 Hrs. onths Days Hours Min.		8. Date of Birth (Month, Day, Year) OCT 23, 1917		Birthplace (State or Foreign Country) MARYLAND			
	D	Usuel Residence of												
	d 2 should be filed within 72 hours after death with the Maryland and Menlel Hygiane. 7 is marked other than "natural", or hems 23s or 28s-f show treumstic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	10a. State		10c. City, Town or Location							1	0d. Inside City Limits		
		MD	GARRET	T	OAKALND								1 X Yes 2 No	
		10e. Street and Number 10f. Zip Code 10g. Citizen of What of the Code 10g. Citizen of Code 10								What Coun	itry?			
e, Marylan	th w	125 CROOM	K CREST					215	550		USA			
	ine ine	11. Marital Status	12. Wes De	de completed) College (1-4or 5+)		13. Was De	cedent of	f Hispanic Origin? (Specify Yes or No- ban, Mexican, Puerto Rican, etc.)		14. Race - American I Black, White, etc.				
	urs after sir, or hi Examina by Fu	1 ☐ Never Marri 3 🔀 Widowed	d 1 ☐ Yes If Yes, C			1 ☐ Yes 2 🖾 No Specify:			Specia					
	2 ho	(0-0-0	Education			6a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) HOMEMAKER			ina	16b. Kind of B	6b. Kind of Business/Industry			
	be filed within 72 hor tel Hygiane. d other than "natura event, tre Medical Be Completed	Elementary/Seco							OWN HOMI		ME	ΙE		
	Hyg Hyg	17. Father's Neme	(First, Middle, La	1)					18. Mother's Nam	e (First, Middle,	Maiden Sumame)			
	should be nd Mentel marked o urmatic ev	SAMUEL	BAKEF	2	ARONHALT			PEARLE		MAGDALINE LAWTO			ON	
	Shound M ment	19a. Informent's Na	ame/Reletionship	me/Reletionship (Type, Print) 19				. Mailing Address (Street and Number or Ru			lural Route Number, City or Town, State, Zip Code)			
	and 2 selith an n 27 is ier treu	JAMES MO	ORE - SC	N		7	00 "K"	ST	REET	MT. LAK	E PARK,	MD 2	21550	
	ーエミシ	20a. Method of Disp						Disposition (Name of		Date 20c. Location - City		- City or To	or Town, State	
	0 - 5				Removal from State GARRETT MEMORIAL GARDENS				2/13/99 OAKLAND, MD 21550					
	크 된 된 글 .													
89	Depa Impo	22. Name and Address of Facility P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD 21550												
		June	MUN											
	Physician /Medical	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximation of the mode of dying, such as cardlac or respiretory arrest, interval B conset are.									Interval Between Onset and Death			
		Immediate Cause (Final												
	Examiner	disease or condition resulting in death)	n	e. Pa	Pancientie Concer							4	MONTHS	
					Due to (or as e consequence of):									
	executed in and iel-transit Examiner			b	b									
	ate be executed hysician and the buriel-transit	Sequentially list con if eny, leeding to im	nditions, nmediate		Due to (or es e consequence of):									
760,	ysician ysician a buric	Cause (Disease or	erlying Injury	C								1		
687	phys s tha	that initiated events resulting in death) I	Last		Due to (or as a consequence of):							1		
×	ding sa e			d										
Вох	death certifical e attending phy d for usa es th									1				
	0 0 0	Part II. Other signif	licant conditions	contributing to	ributing to death but not resulting in the underlying cause given in Pert I.					23b. Did tobacco use contribute to the cause of death				
	ed by deta								1 Yes 2 No 3 Probably 4 Onknown					
	law requiras that the as been signed by the 2 should be detached prince of the assert that the state of the s										24b. W	ere eutopsy findings		
Ö	v require been sit should t										performed?		allable prior to mpletion of cause	
<u> </u>	The law requir									_ 12		of death?		
	Con				1 ☐ Yes 2 🖾 No								☐ Yes 2☐ No	
	ysiclan: The lav is certificate has director, paga 2 fo Be Comp	25. Wes case reference examiner?	red to medical	Hoopital	Hospital: Other: ATT No. 1 ATT NO. 1 A									
	E C = '	1 Yes 20		11	1 Inpatient 2 EH/Outpatient 3 DOA 4K Nursing Home 5 Hesidence 8 Dother (y)	
	tending Phy beth. tor: After this the funeral c	27. Menner of Deeti 1 Natural	5 Pending		e of Injury onth, Day Year,	28b. I	njury	28c. Inj		28d. Describe how Injury occurred		rred		
Sic	Attending or deeth. ctor: After by the fune fune fillication.	2 ☐ Accident 3 ☐ Sulcide	Investigat	ho .						201 Leveline (Charles and Munch and David Review Munch				
Division	2005 =	4 Homicide	determin	286. Plac	ce of Injury - A Iding, etc. <i>(Spe</i>	nome, fa	rm, street, fac	tory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	Urs a Urs a Ce													
	To the Hospital or within 24 hours after To the Funeral Direction plately filled in the Medical Certi	29a. Certifier (Check only	1 X Certifying 2 ☐ Medical Ex	aminer: On the	basis of exem	nowledge inetion end	, death occurr Dor Investigat	ed at the i	time, date and place, oplnion, deeth occur	end due to the or red at the time, or	euse(s) and m late and plece,	anner as s , and due to	tated. o the cause(s)	
	the the smpla	one) 29b. Signature and	title of contilion	end me	enner stated.			29c Lines	nse number		29d. Date sign	ed (Month	Day, Year)	
			THE OF POSTURES								wind audit	Sinister Let 10		

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANTET MILLER, D.O. 69 WOLF ACRES DRIVE 31. Date filed (Month, Day, Year) FEB 1.1 1999



H26154

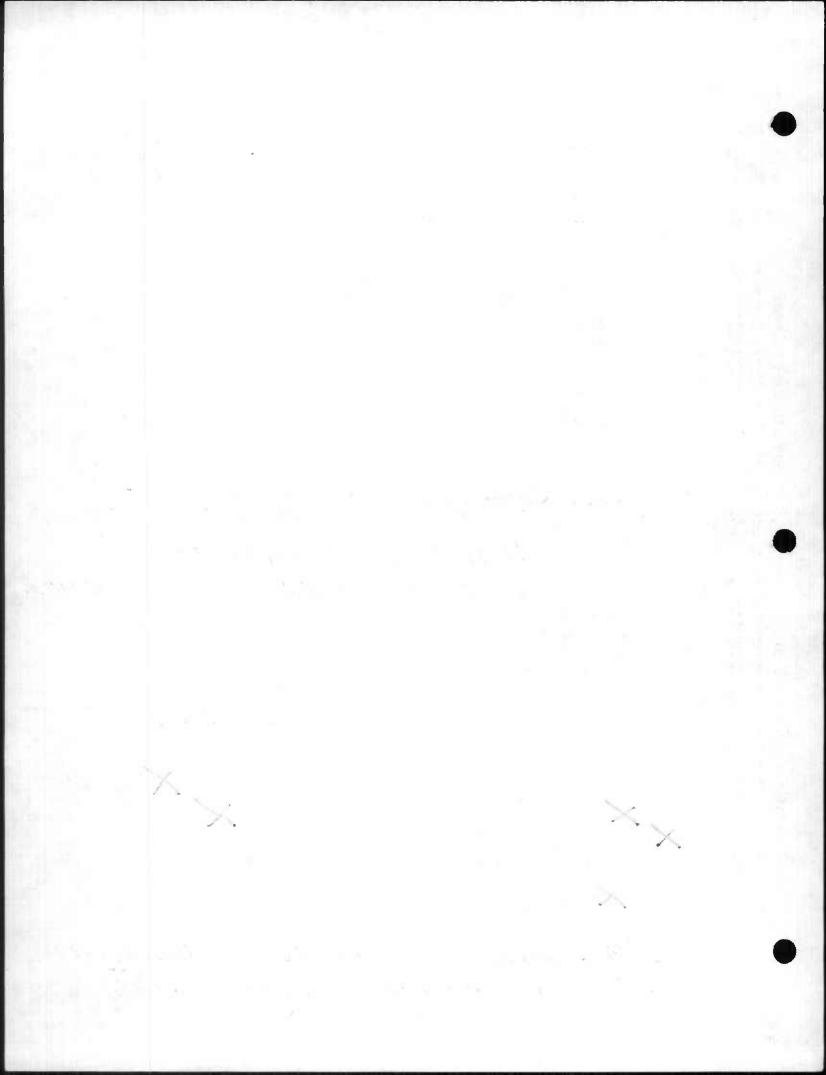
FEBRUARY 11, 1999

OAKLAND, MD 21550

Piease Type or Print in Biack Indelibie Ink. Assure Aii Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 051.69

ician				Certificate	e or De	eatn	Reg	a. No.	00403
cian	1. Decedent's Name (First, Middl	le, Last)					2. Date of Death Month	Day Yea	3. Time of Death
dical	Nanci Lee Na	athan					Februar		
niner	4a Facility Name (If not institution)		4b. (City, Town, or L	ocation of Death	4c. County of De	
	9609 Eldwich	Z Mari				Potoma	0.0	Monto	romerv
al	5. Social Security Number	6. Sex 7. A	ge (In yrs. last bi	irthday) If Under Months		Under 24 Hrs.	8. Dete of Birth (Month, Day, 1	0.1	Birthplace (State or Fore Country)
or	220-42-3711	1□M 2√X	53	Yrs.	Deys	Hours Min.	Sept. 2		D. C.
	220-42-3711 Usuel Residence of Decedent								
	10a. State 10b. County		10c. City, Tow	vn or Location					10d. Inside City Lim
ot o	Maryland Mont	gomery	Potor	mac					1 ☐ Yes XZX
Director	10e. Street and Number			10f, Zip	Code		10	g. Citizen of What	Country?
	9609 Eldwick Way	v			2085	4		U. S. A	Α.
Funeral	11. Marital Status	12. Wes Deceden		13. Was Deced	lent of Hispa	anic Origin? (Sp	pecify Yes or No- Rican, etc.)		merican Indien,
교	1 Never Married 2 Men	ried 1 Yes 20					rucan, etc.)	Black, W	nite, etc.
ò	3 ☐ Widowed ★ ₩ ivorced	Year or Dates:		1□Yes %	(XI NO S	Specify:		Specify:	White
Completed		t's Education	16a	. Decedent's Usue	l Occupatio	n	10	Sb. Kind of Busine	ss/Industry
8	Elementary/Secondary (0-12)	st grade completed) College (1-4or	5+)	(Give kind of wor. life. DO NOT us	k done dun se retired)	ng most or won	ang		
0		2 Years		haritable	Fund	Raisi	10	Philant	hropy
80	17. Father's Name (First, Middle,						e (First, Middle, Ma	aiden Sumame)	
0	Harry Laskin					Rhoda I	Himelfarb		
	19a. Informant's Neme/Reletions	hip (Type, Print)	198	b. Meiling Address	(Street and		ral Route Number,	City or Town, State	a, Zip Code)
	Larry Greenba		9	609 Eldwi	ick Wa	y, Poto	omac, Mar	yland 20	854
	20a. Method of Disposition		20b. Plece o	of Disposition (Nam	ne of		Date 20	Oc. Location - City	or Town, Stete
	1 Buriaf 2 Cremetion			ary, cremetory or of		1	17/00	1 14	
	4 th Donation 5 ☐ Other (S		Judea	n Memoria			7799 0	lney, Ma	ryland
	21. Signature of Funeral Service	2 A					. W	1 (1) 1	T
	23a. Part1. Enter the diseese, or shock, or heart feilure. List	. Xtottle	myer	Danzar	JEKY-C	2010ber	g Memoria	i Chaper	S, IIIC.
Examiner	resulting in death)	· WI	6 C	consequence of):	ON	14	ALL CE		4MO.
Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or es a	consequence of):					
n/Medical	Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or es a	consequence of):					
5	resulting in death) Last				Busa nivan i	n Part I	23h Did toh	acco usa contrib	internation of the
5	that inflieted events				ause given i	n Pert I.	1		
Physician/M	resulting in death) Last				ause given i	n Pert I.	23b, Did tob		
by Physician/M	resulting in death) Last				ause given i	n Pert I.	1) Yes	autopsy 24	Probably 4 Unite
by Physician/M	resulting in death) Last				ause given i	n Pert I.	1700	autopsy 24	b. Were autopsy findin aveilable prior to completion of cause
by Physician/M	resulting in death) Last				ause given i	n Pert I.	24a. Wes an performe	autopsy 24	b. Were autopsy finding aveilable prior to completion of cause of death?
Completed by Physician/M	resulting in death) Last Part ff. Other significant condition	ons contributing to death					24a. Wes an performe	autopsy 24	b. Were autopsy findin aveilable prior to completion of cause
Be Completed by Physician/M	Part ff. Other significant conditions 25. Was case referred to medical examiner?	one contributing to death	but not resulting i	in the underlying ca	20 Other	5. Place of Dee	24a. Wes an perform	autopsy 24	b. Were autopsy finding aveilable prior to completion of cause of death? 1 Yes 2 No
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Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY 5, 1999 **Physician** 5:45AM ANNATOL NATOV-POPLUIKO /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Name (If not institution, give street and number) **Examiner** MONTGOMERY KENSINGTON MARINER HEALTH CARE OF KENSINGTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 7, 1909 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthdev) **Funeral** Months Days Hours Min 1 M 2 F Ukraine Yrs. 057-34-9598 89 Director Usuel Residence of Decedent r 28a-f show a notified at 10a. Stete 10b. Count 10c. City, Town or Location 10d. Inside City Limits The Marylar 1 ☐ Yes 2 ☐ No Directo Montgomery Kensington Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23s or edical Examiner must be r USA 20895 Funeral 3707 Emily St 14. Rece - American Indien. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status Black, White, etc. hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ▼ No Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 72 then Elementery/Secondary (0-12) College (1-4or 5+) Hygiene. Radio Economist permit. Pages 1 and 2 should be file.
Department of Health and Mental Hype Important: If them 27 is many any injury or other pages. marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Anna Wollenberg Ivan Natov-Popluiko 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3707 Emily St, Kensington, MD 20895 Nadine Natov-Popluiko/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Buriel 2 Cremation 3 DRemoval from State 4 ☐ Donetion 5 ☐ Other (Specify) Rock Creek Cemetery Feb 8 Washington, DC 21. Signature of Funeral Service Licenses 22. Name end Address of Facility Hines-Rinaldi Funeral Home (Blan 11800 New Hampshire Ave, Silver Spring, MD 20904 000 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Weeks Septicemia Examiner Due to (or es e consequence of): Examiner Months Gangrene physician and s the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Peripheral Arterial Insufficiency Years Box 68760. Physician/Medical Due to (or as a consequence of): 88 attending p for use as 23b. Did tobacco use contributa to the cause of death? P.O. ed by the a Pert II. Other algorificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Multi Infarct Dementia Division of Vital Records. þ 24b. Were autopsy findings aveilable prior to should b 24e. Wes en eutopsy performed? Completed Arteriosclerotic Heart Disease completion of cause of death? has 925 page 1 Yes 2 DNO certificate or Attending Physician: 25. Was cese referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 XNursing Home 5 ☐ Residence 6 ☐ Other (Specify) 10 1 Yes 2M No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. tnjury et Work? 28d. Describe how injury occurred Certification: 1 X Neturel 5 Pending Investigation thin 24 hours after death.

the Funeral Director: After Ampletaly filled in by the fur 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and menner as stated. edical 29a. Certifie (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end menner stated. To the Within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D08944 February 5, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin C. Shargel 3720 Farragut Ave, Kensington, MD 20895

Registrar **DHMH 16 Rev 6/95**

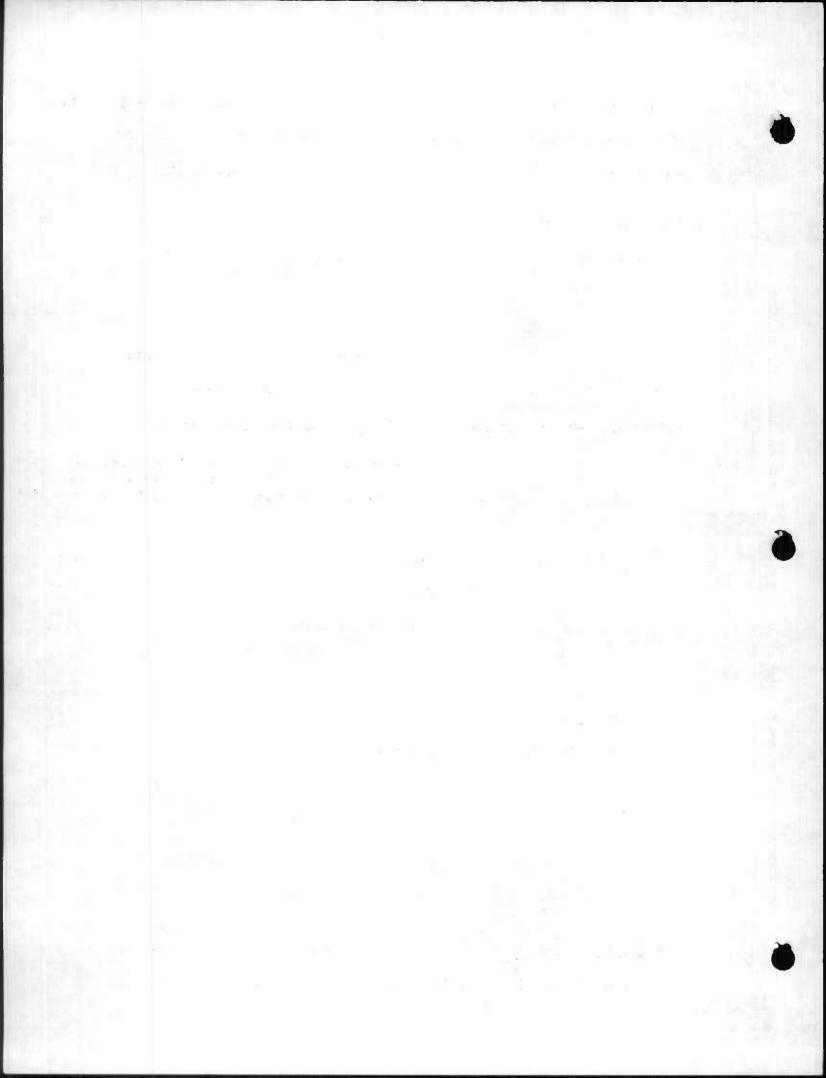
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31. Date filed (Month, Day, Year)

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32. Registrer's Signeture

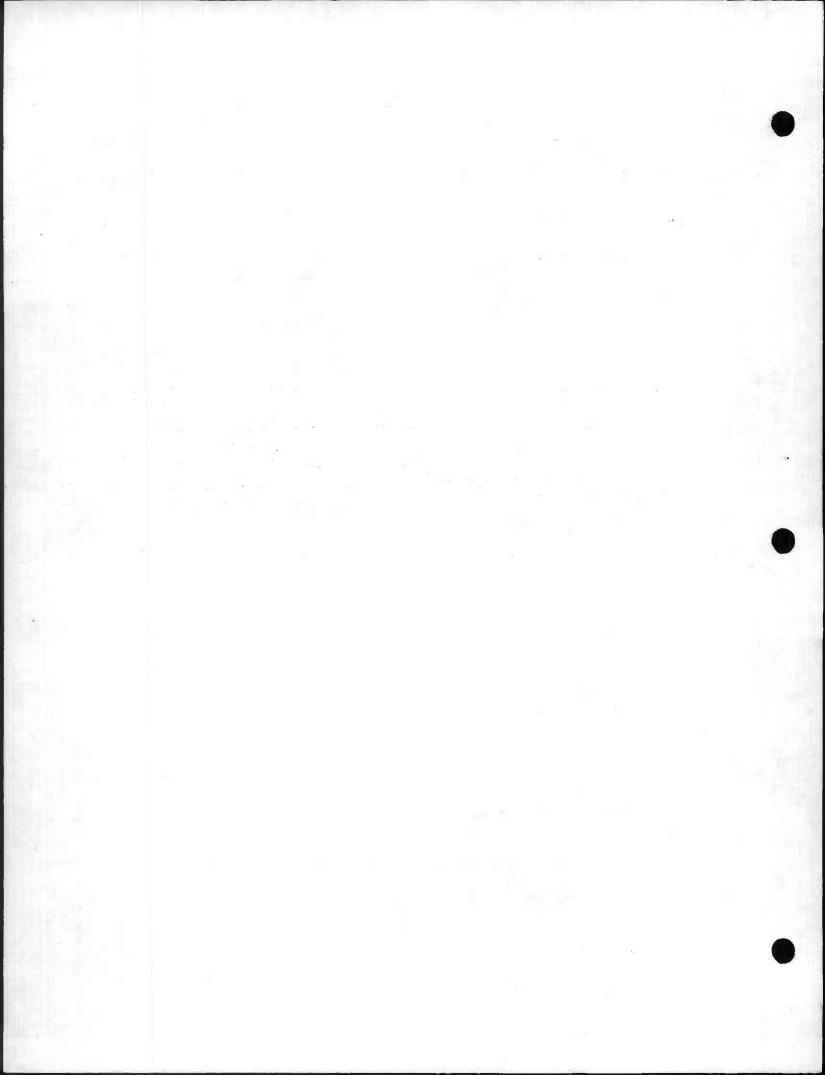
souls!



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State of Maryland / Department of Health and Mental Hygiene 9 054.7

				Cer	tificate o	f Death	F	Reg. No.	00	
		1. Decedent's Neme (First, Middle, Last)					2. Date of Dee	th Dey	Yeer	3. Time of Death
	Physician /Medical	Exythe	M.	N	emo		February	6	999	11:25 AM
	Examiner	4e Facility Name (If not institution, give :	street and number)			4b. City, Town, or	Location of Death	4c. County	of Death	
		Shady Grove Ad	ventist Ho	ospital		Rockvi		Mont	gome	rv
	Funeral	5. Social Security Number 6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Yes		8. Date of Birth (Month, Da)	Year)		ce (State or Foreign
	Director	189-40-3232	90	Yrs.				5, 1909	Penns	ylvania
	P	Usuel Residence of Decedent 10a. State 10b. County	10c.	City, Town or Loc	ation				10	d. Inside City Limits
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_	Pun film	1 Never Married 2 Merried	Armed Forces? 1 ☐ Yes 2 🔀 No	If	Yes, specify Co	f Hispanic Origin? (S uban, Mexican, Puer	to Rican, etc.)	Blac	k, White, el	
020	by by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2 🗓 N	lo Specify:		Specify.	W	hite
21215-0020		15. Decedent's Educ		16a. Deced	ent's Usuel Occ	cupation		16b. Kind of Bu		
215	ed within 72 ho ygiene. we then "naturn f, the Medical.] Completed	(Specify only highest grade Elementery/Secondary (0-12)	completed) College (1-4or 5+)	(Give I	and of work dor O NOT use reti	ne during most of wo ired)	rking			
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Pu	d offin	17. Fether's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Surnem	θ)	
yla	Ment by Ment b	Peter Americo				Anna		not a	vaila	ble
Maryland	and and and and and and and and and and	19e. Informent's Name/Relationship (Ty)	pe, Print)	19b. Mailin	Address (Stre	et and Number or R	ural Route Numbe	r, City or Town,	State, Zip (Code)
	and a 27 ar tr	George J. Nemo / s	on	2207	Regina_	Drive, Cl.	arksburg	Maryla	and 20	0871
altimore,	or off	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Re		 Place of Dispos cemetery, crem 	ition (Name of atory or other p	(ace) February	9, 1999	20c. Location -	City or Tow	m, Stete
Ē,	Tar the last of th	4 ☐ Donetion 5 ☐ Other (Specify)	M	on Valle	y Memor	ial Park		Donora,	Penn	sylvania
Sall	populari pop	21. Signeture of Funeral Service License	0/1	l RO	Name and Add	fress of Fecility	eral Home/	Retherds-	-Chessy	Chase, Inc.
5	20238	Barbara Jo McM	ullen Jawa	ence 75.	57 Wiscon	sin Avenue,	Bethesda,	Maryland	20814	-3501
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	/Medical Examiner	Immediate Cause (Finel disease or condition	CARDACA	rrest					0	MINUTES
100	SERVICE STATE	resulting in death)		(or es a consequ	uence of):					
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	and and Il-trar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as e consequ	vence of):					
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> :	Physician: this certific ral director,	examiner? 1 Yes 2 No	ospital: 1 Inpatient 2	☐ ER/Outpatient	3□ DOA	Other	lome 5 ☐ Resid		er (Specify))
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	he Hospital or Affending Pin 24 Hours after deeth. The Funeral Director: After the pletely filled in by the funeral edical Certification:	29a. Certifier 1 Certifying Phys	ician: To the best of my ker: On the basis of exami	nowledge, death	occurred at the	time, date end place	e, and due to the d	ause(s) end me	nner as sta	ited.
	untiling a for Hospital or Attending is within 24 hours after dead or To the Funeral Director: After pompletely filled in by the funeral Medical Certification:	one)	and manner stated.	THE RESERVE OF THE PERSON OF T						
	T with	29b. Signeture end title of certifier	1			onse number		29d. Dete signed		
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		30. Name and address of person who con		0 1	rint) Jose	ph A. Bal	1, M.D.	21611		
		11501 GEOVERA		. 001.1	515	whats	VINO	20,105		
	State Registrar	31. Date filed (Month, Day, Year) FFR 0 9 1000	32. Registrar's Sig	B.	Loon	61				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day Month Yaar **Physician** February 6, 1999 3:25 PM Geneva Harrison Newman /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 9312 Piney Branch Road, #305 Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Jan. 14, 1946

9. Birthpleca (Steta or Foraign Country)
District of Columbia 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1□M 21 F 579-56-6116 53 Yrs Director Lisual Residence of Decedent 10c. City, Town or Location 10d. Insida City Limits with the Marylar 28a-f show must be notified at 1 ☐ Yas 2 No Director Maryland Montgomery Silver Spring 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code "natural", or flams 23s or United States 9312 Piney Branch Road, #305 20903 Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puarto Rican, atc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - Amarican Indian, Black, Whita, etc. filed within 72 hours after 1 Nevar Married 2 Married 1 Yas 2 No If Yes, Give Year or Datas: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Department of Hygiene. Elamentary/Secondary (0-12) College (1-4or 5+) Agriculture Secretary 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) permit. Pages 1 and 2 should be till.
Department of Health and Mantal Hy
Important: If Nam 27 is marked othany Injury or other traumatic event Be 10 Elmore Booker Carrie L. Harrison 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) James O. Newman (husband) Same as 10 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Removal from Stata Maryland National Cemetery 2-12-99 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Maryland 22. Nama and Addrass of Facility
Rapp Funeral Services, P. A. 21. Signatura of Funaral Service License 933 Gist Avenue, Silver Spring, MD 20910 23a. Part1. Entar tha disaase, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Approximata** Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaase or condition rasulting In death) HIV Examiner Due to (or as a consequence of): Examine Encephalopathy attending physician and for use as the burial-transit certificate be executed Sequentially list conditions, if any, laading to immediata cause. Entar Underlying Causa (Disease or Injury that Initiated evants rasulting in death) Last Dua to (or as a consequence of): Box 68760, Physician/Medicai Due to (or as a consequence of): ES I P.O. the Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown The law requires that Records, by 24b. Wara autopsy findings available prior to complation of causa of death? Completed 24a. Was an autopsy peen page 2 certificate has 1 ☐ Yes 2X No 1 ☐ Yas 210 No of Vitai Physician: 25. Was casa refarred to medical axaminar? Be 26. Place of Deeth (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 1 Yas 2 No Certification: To this 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 27. Manner of Death 28c. Injury at Work? 28d. Dascribe how injury occurred To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After ti completaly filled in by the funera After t Division 1 XNatural 5 Pending invastigation 1 Yas 2 No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicida 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida Medicai 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, date end place, and due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a, Cartifier (Check only one) 29b. Signature and title of certifier 29d. Data signed (Month, Day, Year) 29c. License number D00143 February 8, 1999 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Hubert J. Alpert, M.D., 8630 Fenton Street, Suite 230, Silver Spring, MD 20910

Registrar

State

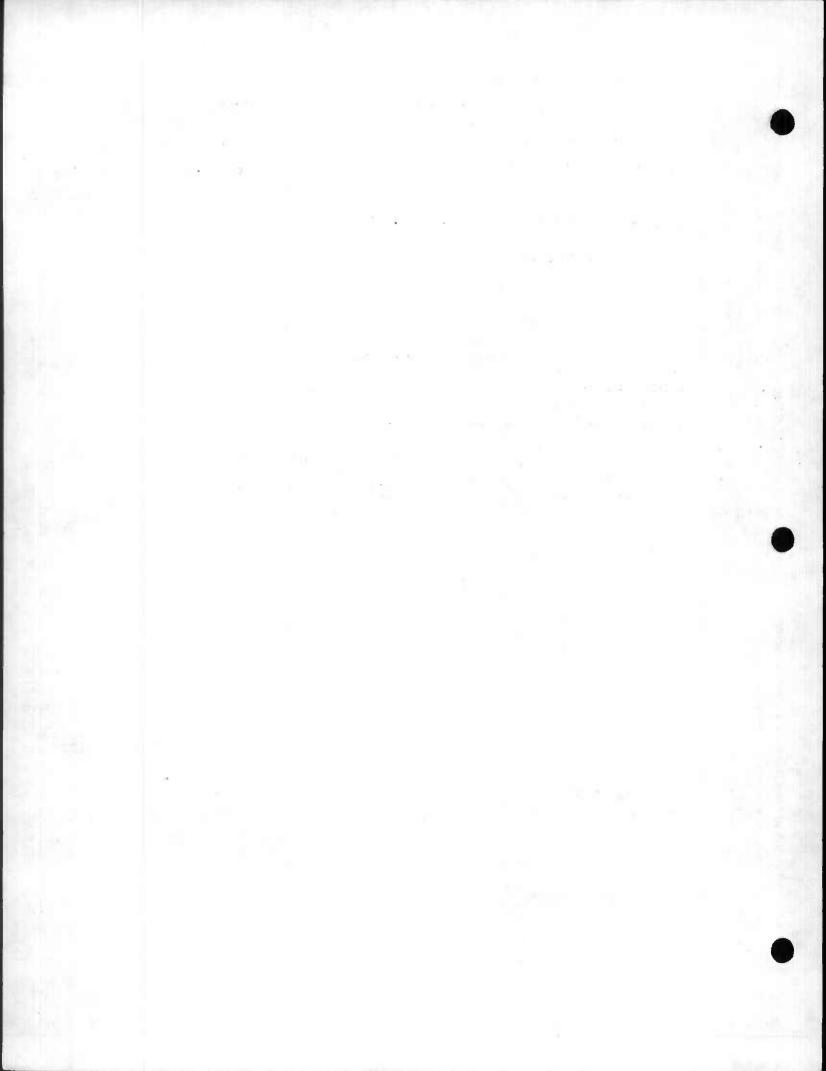
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1999

32. Registrar's Signatura

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death February 4, 1999 Physician Sara Nussbaum 1:00 A.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 1801 East Jefferson Street #504 Rockville Montgomery County 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1□M 2 F 130-05-6321 Director **Usual Residence of Decedent** 10a. State **ehow** 10b. County 10c. City. Town or Location 10d. Inside City Limits Name of the countries o Maryland Montgomery 1X Yes 2 No Rockville Director 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zip Code 1801 East Jefferson Street #504 20852 of America Peges 1 and 2 should be filed within 72 hours after deeth nant of Heelth and Mantel Hyglens.

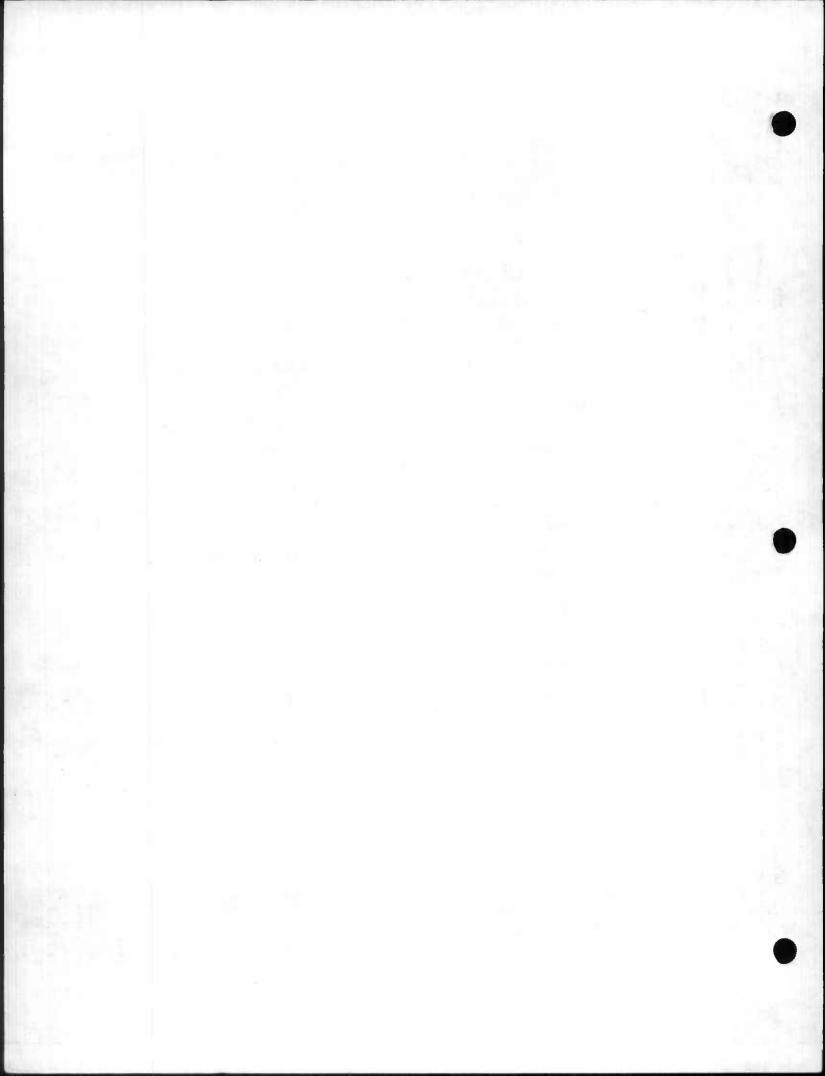
ant: if item 27 is marked other than "natural", or itema 23 ury or other treumsits event, the Medical Examinar must 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No N Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify: White Š 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Saitimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Naftali Schachter Mirl Gelber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Nussbaum / Son 3815 Leland Street, Chevy Chase, Maryland 20815 20b. Place of Disposition (Name of cometers, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Feb. 4, 1 Burial 2 Cremation 3 Removal from State West Patterson permit. Pege Department of Important: If eny injury or page. 4 Donation 5 Other (Specify) 1999 New Jersey Verein Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Jewish Memorial Chapel ouser 66 Howe Avenue, Passaic, New Jersey 07055 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) CANCER OF COLON, METASTAS Examiner Examiner The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): physicien e Box 68760. Physician/Medical Due to (or as a consequence of): for use es signed by the st id be deteched fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown DREGANIC BRANN à 24b. Were autopsy findings svailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed 100 After this certificate funeral director, pag 250 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital or Attending Physician: 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 1 Natural
2 Accident 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Mi Kosen D104766 Danies 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAMEL ROSENBUM, MD 10400 CONNECTICUT EVE STEGOL KENSINGTON, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

FEB 10 1999



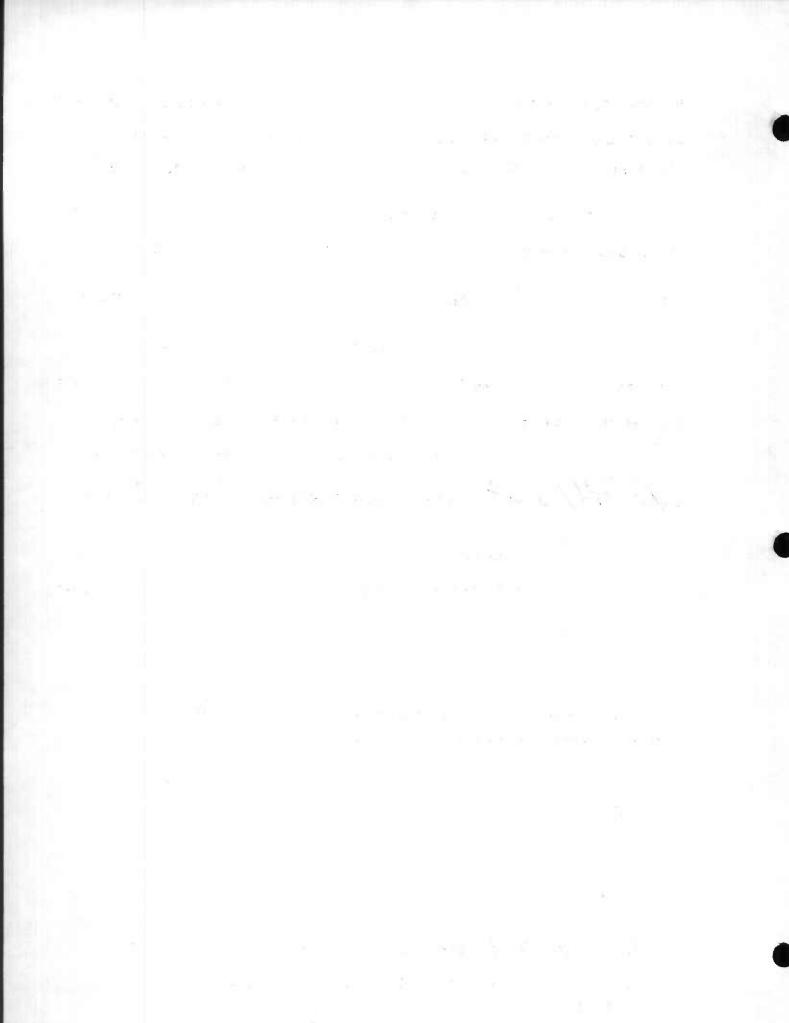
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eral ctor	5	5. Social Security Number 212–38–8165	6. Sex 1 □ M 2 XX F	7. Age	(In yrs. last I	birthday) _ Yrs.	If Under 1 Year Months Deys			8. Data of Bir (Month, De NOV 9,	rth ey, Year) 1914	9. Birthpl Count WV	lece (State try)	or Foreign
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other tr		Anne Grant - d 20e. Method of Disposition	aughter		20h Plece		E. ALDER	R STRI	EET	OAK.	LAND, MI 20c. Location			
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State

Registrar

31. Dete filed (Month, Day, Yeer) 32. Registrer's Signature FEB 12 1999

B. Sparks



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State of Maryland / Department of Health and Mental Hygiene 99 054.75

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permit. Pages 1 and 2 Department of Health Important: If Item 27 is any injury or other tre once.		20e. Mathod of Disposition 1		cameter	y, cramat	ion (Nama of tory or other pie		İ		20c. Location	· City or To	wn, Stete
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To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this cartificate he completely filled in by the funeral director, page	Certification:	3 Suicida 6 Could not be datarmined	28e. Pleca of Injury - building, etc. (Sp	At home, far pecify)	m, street	, factory, office		2	8f. Location (Str City or Town		per or Rura	i Route Number,
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death 1. Decedant's Name (First, Middle, Last) 1999 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street end number) URSING HOME ESTMINSTER Under 24 Hrs. 8, Date of Birth ARROL STMINSTER 5. Social Security Number 6. Sex last birthday) Days 10 M 20 F 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yes 2 No 10g. Citizen of What Country? 14. Race - Amarican Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yas 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1 TYas 1 Yes 2 No Specify: WhitE Specify 3 ₩idowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede complated) College (1-4or 5+) Elementary/Secondary (0-12) CIERICAL EDUCATION 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) SUDINA MICHAEL IZABETH 20a. Method of Disposition cemetery, cremetory or other piece, THE ASSUMPTION 1 Burial 2 Cramation 3 Ramoval from State 4 Donation 5 Other (Specify) 21. Signeture of Funeral Service License PRIHS FUNERAL HOME : Chapel 412 WASHINGTON ROAD WESTMINSTER, Mb. cations that caused the death. Do not enter Approximata Interval Betwaan Onsat and Death deu Immediate Cause (Final disaase or condition resulting in death) Due to (or as a consequence of): monto Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest C D C Due to (or as e consequenca of) 23b. Did tobecco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert f. 1 Yes 2000 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? completion of causa of death? 1 Yes 2 No 26. Place of Death (Check only one)

Physician /Medical Examiner

important: If it any injury or c Department

Physician

· /Medical

Examiner

Director

Funeral

2

Completed

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show treumatic event, the Medical Examinar impation nothed as

Peges 1 and 2 should be filed within 72 hours efter deeth with to not of Health and Mental Hygiene.

nt: If Item 27 is marked other than "natural", or items 23a or 2

Baltimore, Maryland 21215-0020

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physicien and the burial-transit for use es page 2 s director

Physician/Medicai Examiner by Completed Be 10 Certification:

that the death certificate be executed Division of Vital Records, P.O. Box 68760, signed by the a d be deteched f certificate has or Attending Physician: After this funeral efter death. Director: Af in 24 hour.
the Funeral Directory filled in by the Hospital

edicai

25. Was case referred to medical exeminer? Other:

Nursing Home 5 □ Rasidenca 6 □ Other (Specify) 1□ Yes 2☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA 28a. Dete of tnjury (Month, Dey Yeer) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accidant 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number. City or Town, Stete) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homlcide 29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Dey, Year)

of death (Jiem 23a) (Type, Print) 30. Name and 00

John Middleton, M.D.

State Registrar

(Month, Day, Year) 32. Registrar's Signatura FEB 0 9 1999

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edical Examiner must be notified at leted by Funeral Director	11. Marital Status 1 Nevar Marriad 2 Married 3 Widowed 4 Divorced	12. Was Decedant Armed Forcas' 1 Yas 2 If Yes, Giva Yaar or Datas:	Evar in U,S.	13. Was Dece If Yas, spi	edent of h	Hispanic Orig an, Mexican,	nin? (Specify Yes or Puarto Rican, atc.)		ce - American	indian,
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	29a. Certifier (Check only one) 29a Certifier (Check only one) Check only one) Check only one) Check only one) Check only one)									ted. he cause(s)
Ne Me	29b. Signature and title of partities	grio mailirar si		25	c. Licens	se number		29d. Data sign	ed (Month, Di	ay, Year)
> - 0	Vatural 1_				1)2	0806		2/6	189	
	30. Name and address of person who ATRICK TUR 31. Data filed (Month, Day, Year)	was, up	leath (Item 23a) (Type, Print)	Bol	TY RI	o ell	DORSBURG	3 MD	21784

State Registrar

DHMH 16 Rev 6/95

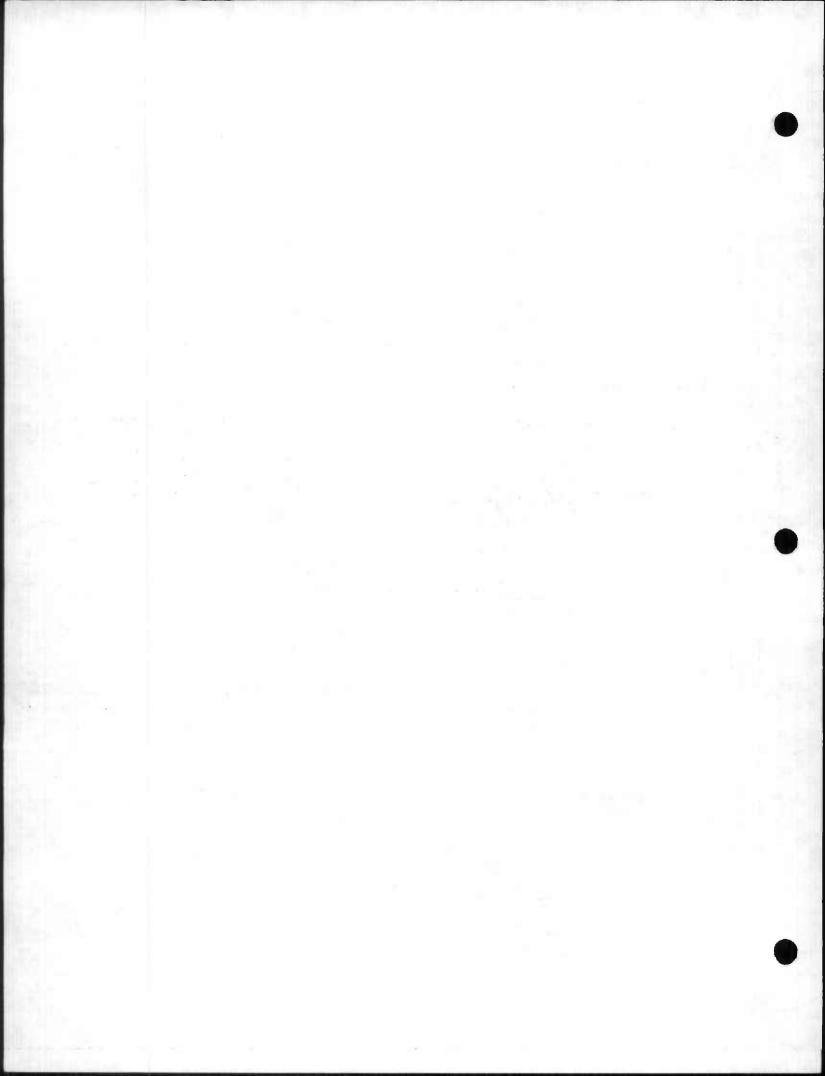
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31. Data filed (Month, Day, Year)

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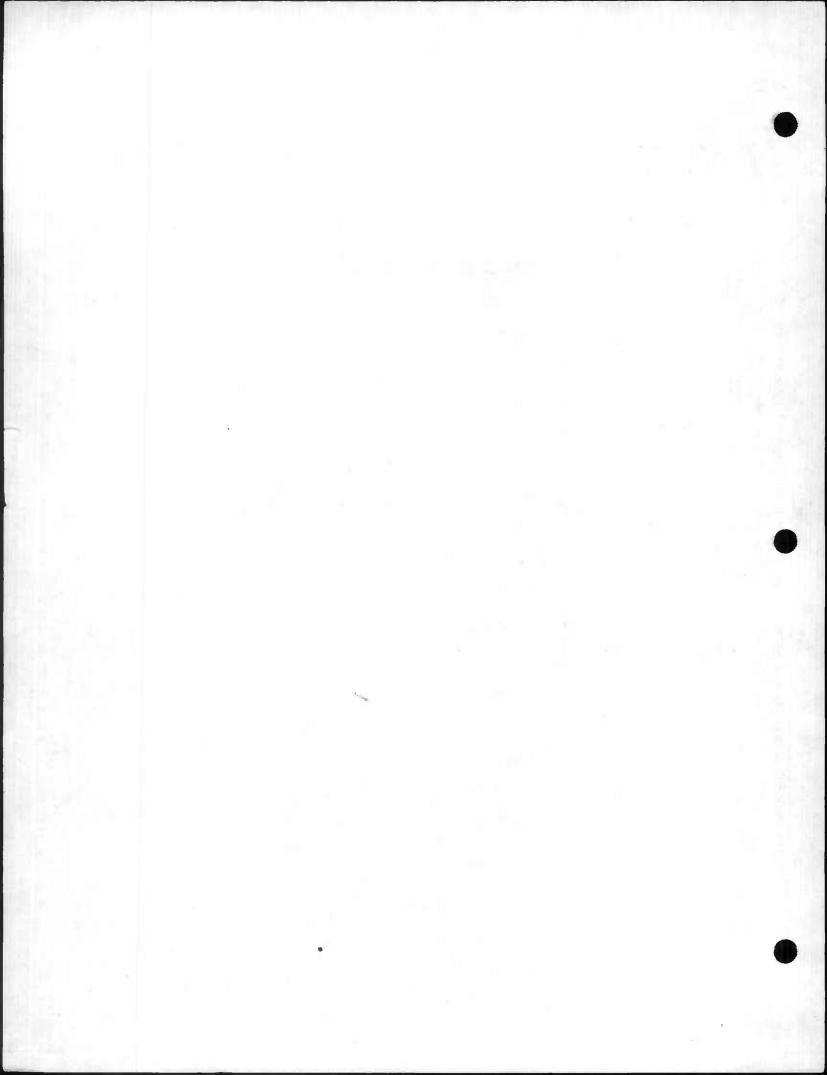
32. Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibie.

State of Maryland / Department of Health and Mental Hygiene

1. Decedent's Name (First, Middle, Last al CHANG RO PAK 4a Facility Name (If not institution, give						2. Date of Dea Month	Day		ime of Death
de Facilità Nome (léactionine si le								Year	. / 0701/
THE SECOND NAME OF DOCUMENTS OF THE PROPERTY O				- 4	tb. City, Town, or Lo	FEBRUAR cation of Death	Y 4, 19		:40PM_
HOLY CROSS HOSPIT									
5. Social Security Number 6. Se		(In yrs. last b	nirthday) If U	nder 1 Year	SILVER SP	8. Date of Birth		GOMERY 9 Birtholace (State or Foreign
	XM 2□ F	50	Yrs. Mon	ths Days	Hours Min.	(Month, Dey JULY 10	Year)	KOREA	State or Foreign
10a. State 10b. County		10c. City, To	wn or Location					10d. In:	side City Limits
MARYLAND MONTGOME	RY		SILVE	R SPRI	NG			10	Yes 2 Tho
MARYLAND MONTGOME 10e. Street and Number			10	. Zip Code		1	0g. Citizen of V	Vhat Country?	
	ENUE			209	05	U	NITED S	TATES	
405 SOUTH VIEW AV 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ev Armed Forces?	ver in U,S.	13. Was D	ecedent of H	lispanic Origin? (Spean, Mexican, Puerto	city Yes or No-	14. Rac	e - American Ind k, White, etc.	lian,
3 □ Widowed 4 □ Divorced	1 ☐ Yes 2√☐ No If Yes, Give Year or Dates:	•		es 21/No	Specify:		Specify		
15. Decedent's Edu (Specify only highest grad		16	a. Decedent's		ation during most of worki	na	16b. Kind of Bu	usiness/Industry	
15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	OT use retired	1)			DUCTNE	00
47 Fathada Nama (Cinst Stidella Lant)	3		STORE	OWNER	18. Mother's Name			BUSINE	22
m .								/	
DUK LAE PAK 19a. Informent's Neme/Relationship (7)	ima Print	40	h Meiling Ad-	trace /Ctract	SOON IL and Number or Rura		City or Tour	State 7in Code	1)
	ype, riili)								
SOON PAK/WIFE 20a. Method of Disposition		20b. Place	of Disposition	(Name of	W AVENUE			MD 209 City or Town, S	
1 ⊠ Buriaf 2 ☐ Cremation 3 ☐ F		cemet	ery, crematory	or other place					
4 Donation 5 Other (Specify)		NORBE	CK MEM			/8/99	OLNEY,	MD	
21. Signature of Funeral Service Licens	600			e and Addre	SS OF FACILITY LDI FUNER	AL HOME	. INC.		
23a. Pert 1. Enter the disease, or comp shock, or heert feilure. List only of	Di Mie	2	11800	NEW H	AMPSHIRE	AVE SIL	VER SPR		20904 eximate
tmmediate Cause (Final disease or condition resulting in death)		ue to (or as	a consequence			100		ł	EEKS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. <u>HEPATOC</u> D HEPATIT	ue to (or as a	AR CARC					3 MO	NTHS
resulting in death) Last	C		consequence	of):					
<u> </u>						1			
Part II. Other significant conditions co	ntributing to death but	not resulting	in the underly	mg cause giv	en in Part I.				ause of death?
ASCITES				-		1 1 1	●\$ 2⊔ No	3 Probably	X Unknown
ESOPHAGEAL VA	RICLES					24a. Was a perfor	n autopsy med?	available	ion of ceuse
						1 🗆 Y	es 2X No	1 ☐ Yes	2□ No
25. Was case referred to medical examiner?					26. Place of Deeth	(Check only or	16)		
examiner/ 1 Yes 2 No	Hospital: 1 🕅 Inpatient	t 2 ER/C	Outpatient 3E	DOA Oth	er: 4 Nursing Ho	me 5 Resid	ence 6 □Oth	er (Specify)	
27. Manner of Death XXNetural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Day	Year) 28b	Time of Injury M	28c. Injur Wor 1 🗆	yat k? Yes 2 □ No	28d. Describe h	ow injury occur	red	
27. Manner of Death XX Netural 5 Pending	28e. Place of Injur building, etc.	y - At home, (Specify)	farm, street, fa	ctory, office		28f. Location (S City or Tow		per or Rural Rou	te Number,
29a. Certifier 1 Certifying Phy	sician: To the best of iner: On the basis of e and manner state	examination a	ge, death occu and/or investiga	rred at the tir ation, in my o	me, date and place, a pinion, death occurr	and due to the c ed at the time, o	euse(s) end ma late and place,	anner as stated. and due to the o	cause(s)
29b. Signature and title of certifier	1			29c. Licens	e number	1	9d. Date signe	d (Month, Dey,	Year)
1 0 W	1-1-	_		D250	07	177	EDDITA DE	E 100	0
		// man 020	\ (Type Print)	D350	0/	F	LDKUAKY	5, 199	7
30. Name and address of person who co	ompleted cause of dec	atri (item 234	/ () po, I inte						
30. Name and address of person who con JOSEPH J. GENOVES				K DRIV	E SUITE 6	SILVER	SPRING	, MD 20	902



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death **Physician** FEBRUARY ALLISON PARKE 5 1999 5:20 AM /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Mt. Airy Pleasant View Nursing Home Carroll If Under 1 Yaar If Under 24 Hrs.
Months Days Hours Min. 8. Data of Birth (Month, Day, Jan. 31 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Months 230-10-9816 1,⊠M 2□ F 86 1913 Yrs. New Jersey Director Usual Residence of Decedent with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 77 is marked other than "natural", or items 23s or 28s-f show traumatic event, tre Mexical Examiner must be notified at Frederick Maryland Monrovia 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3513 Runkles Drive 21170 United States permit. Peges 1 and 2 should be filed within 72 hours efter death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner mass once. Funeral 12. Was Decedant Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. 11. Marital Status 1⊠Yes 2□No 1933-If Yes, Give Yaar or Dates: 1939 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No by Specify: White 3 Ø Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 18b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver D. C. Transit 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be William Henry Parke Millicent White P 19a. Intormant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9928 Colorado Court, Damascus, Maryland William H. Parke/son 20872 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Ramoval trom State Ft. Lincoln Cemetery 2/9/99 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Servica Licenses Laytonsville, Maryland 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical month **Examiner** Due to (or as a consequenca of) Physician/Medical Examiner The lew requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last and Dua to (or as a consequence ot) Box 68760. ettending physiclen Due to (or as a consequence of): usa as P.0. Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Part I. the 23b. Did tobacco use contribute to the cause of death? signed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by Division of Vital Records. 8 24b. Wara autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy this certificate hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: within 24 hours effor death.

To the Funeral Director: Aftar this certifica 25. Wes case reterred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 28a. Date of Injury (Month, Dey Year) funarai 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending 1 ☐ Yes 2 ☐ No Investigation the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, tectory, offica building, etc. (Specify) filled in by 4 - Homlcide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the ceuse(s) end menner es stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and mannar stated. 29a. Certifier Medicai (Check only one) 29b. Signature applition opplies 29c. License number 29d. Data signad (Month, Day, Year) 8 026499 * 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

Ronald E. Miller, M.D.

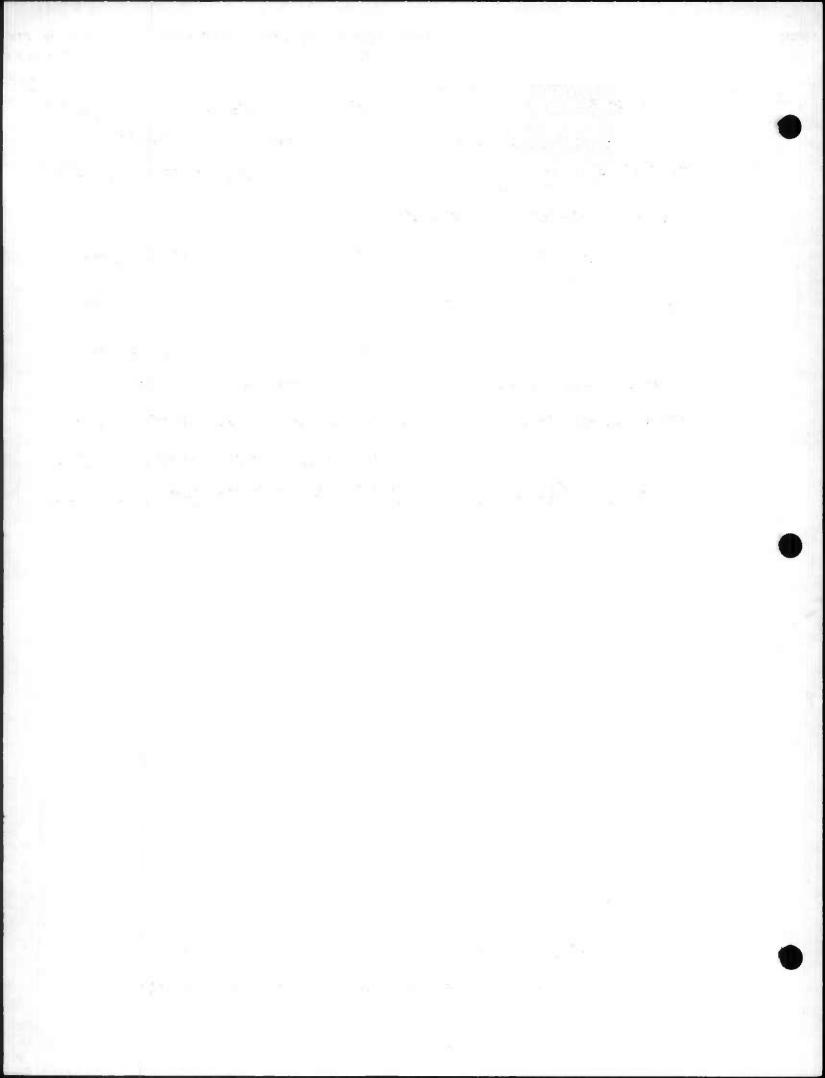
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31. Date filed (Month, Day, Year)

4

32. Registrar's Signature

Culwell Drive, Mt. Airy, Maryland 21771



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

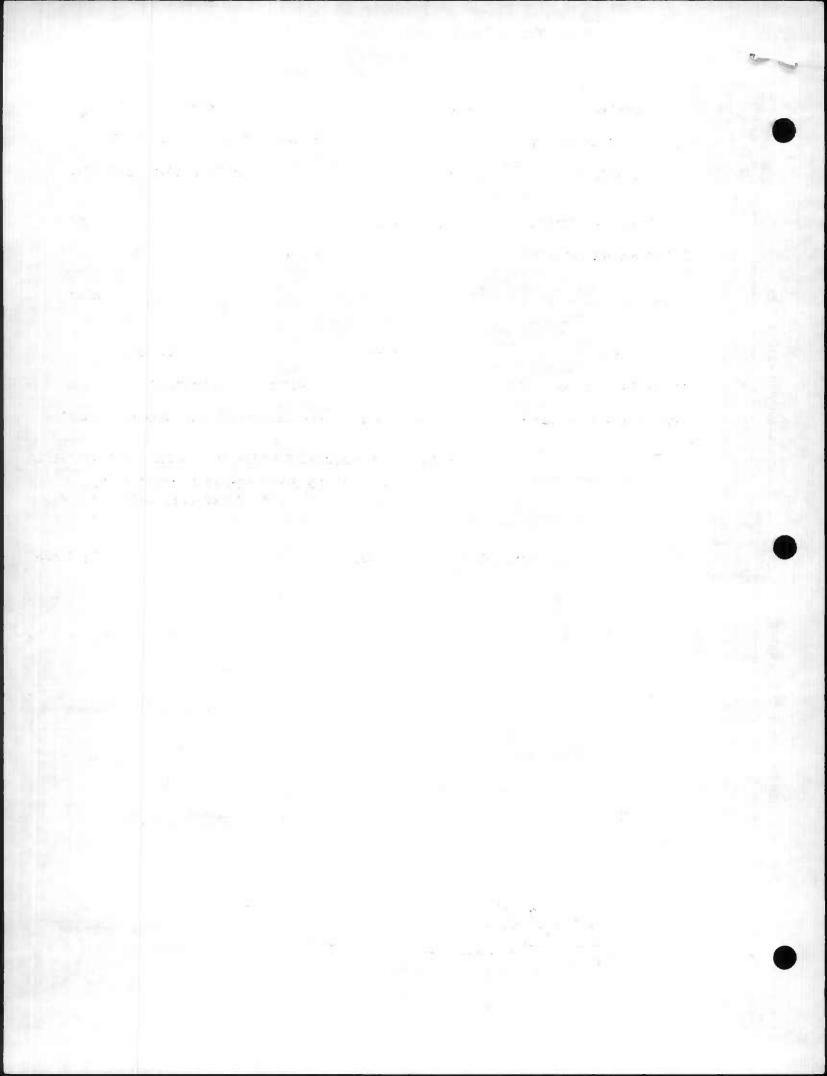
	1. Decedent's Neme (First, Middle, Las	st)					2. Dete of Dee			3. Time of Death
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/Medical Examiner	4a Facility Neme (If not Institution, give					4b. City, Town, or I	ocation of Death	4c. County		
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Funeral	Social Security Number 6. S	Sex 7. Ag	e (in yrs. lest birth		er 1 Year		8. Dete of Birth	Vone	9. Birth	plece (State or Foreign
Director	218-40-7572	□ M 2XXF	83 Y	Months	Deys	Hours Min.	MARCH 8	1915	MICH	IGAN
9	Usuel Residence of Decedent		10 07 7							
show	10a. Siete 10b. County		10c. Cify, Town	or Location						10d. Inside City Limits
the Maryle 28s-f shor notified	MARYLAND MONTGOME	ERY	SILVER							Yes 2 No
with the Marylend a or 28a-f show the notified at Director	10e. Streef and Number	247		10f. Zi	ip Code	20006		10g. Citizen of \ USA		ntry?
£ 2 £	14508 HOMECREST RO		Francis II C	10 Min Door		20906	nosity Van as Na			can Indien,
ter dea	11. Marifel Status	12. Was Decedent I Armed Forces?		If Yes, spi	ecify Cub	Hispenic Origin? (S an, Mexican, Puert	o Rican, etc.)	Blee	ck, White,	
hours after ural; or he	1 Never Married 2 Married Widowed 4 Divorced	If Yes, Give Year or Dates:	40	1 🗆 Yes	XXNo	Specify:		Specify	y: W	HITE
15-002 72 hours "natural",	15. Decedent's Ec		16e. [Decedent's Usi	uel Occur	pation		16b. Kind of B	usiness/Ir	ndustry
1 21215-0 ed within 72 ho ygiane. her than "naturint, the worlest	(Specify only highest gra	ide completed)	(Give kind of w life. DO NOT	ork done	during most of wor	king			
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arylan should be and Mental merked o umetic eve						FLORA	SLHOME	BERGER		
Z 25 Z	19e. Informent's Name/Relationship (JUDY KERSNER/DAUGI					t end Number or Ru ANE GAITH				20878
altimore, M mit. Peges 1 end 3 pertament of Health portant: if item 27 it y injury or other tr	20e. Method of Disposition		20b. Plece of I	Disposition (Ne	ome of	200)	Dete	20c. Location	- City or T	own, Siele
Peges nent of the iry or o	1 N Buriei 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Specific					IAL GDNS2	/5/99 I	FALLS CI	HURCE	,VIRGINIA
Baltimol pemit. Peges Department of Important: If it any injury or once.	21 Signature of Funeral Service Liter		4			GOLDBERG		CHADEI	C TN	IC.
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	23a Part I. Erner the diseese, or com	plications that caused	he death. Do no							Approximete Interval Between
Physician	shock, of heart failure. List only	one cause on each lin	16						i	Onset end Deeth
/Medical	Immediate Ceuse (Final	MEMA CMA	TTC TIME	CANCE	D				1	1½ YEARS
Examiner	disease or condition resulting in deeth)	e. METASTA	TIC LUNC						1	12 TEARS
e e			200 10 (0) 00 0 0	onsequence of	,				1	
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O, axe axe	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury									
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		d								
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Py State T			nt 2 ER/Out		707		lome Resid			ity)
In gran Ing	27. Menner of Deeth 1 Naturel 5 Pending	28e. Dete of Inju (Month, De	ry y Year) 28b. Ti	me of jury M	28c. fnju Wo	ork?] Yes 2 □ No	28d. Describe h	now injury occu	rred	
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Division of standing P rs after deal of prector: After ted in Director: After ted in by the funer Certification:	4 ☐ Homicide determined	building, et	ury - At home, fer c. (Specify)	n, sireet, iacto	ory, office		City or Tow	vn, Stete)	DOI 01 110	or mode reamber,
		veloten: To the heat	of my knowledge	death coours	d at the t	ime date and place	and due to the	causa(s) and m	enner se	stated
ne Hospi n 24 houns Pletaly fil	(Check only 2 Medical Exam	nines: On the best of end manner sto	examinetion and	or investigation	on, in my	opinion, death occu	irred et the time,	dete end plece,	end due	to the ceuse(s)
within 2 To the comple		±#				se number		29d. Date signe		
	12/1/	M			D332	293		FEBRUAL	RY 2	1999
6	20. No ma and address of person who	completed source of d	nally (Itam 22a) /7	Type Brief)				- LIDROIN		

FREDERICK SMITH, MD - 5401 WESTERN AVENUE, NW - WASHINGTON, DC 20015-2998

DHMH 16 Rev 6/95

State Registrar

31. Dete filed (Month, Day, Yeer) FEB 10 1999

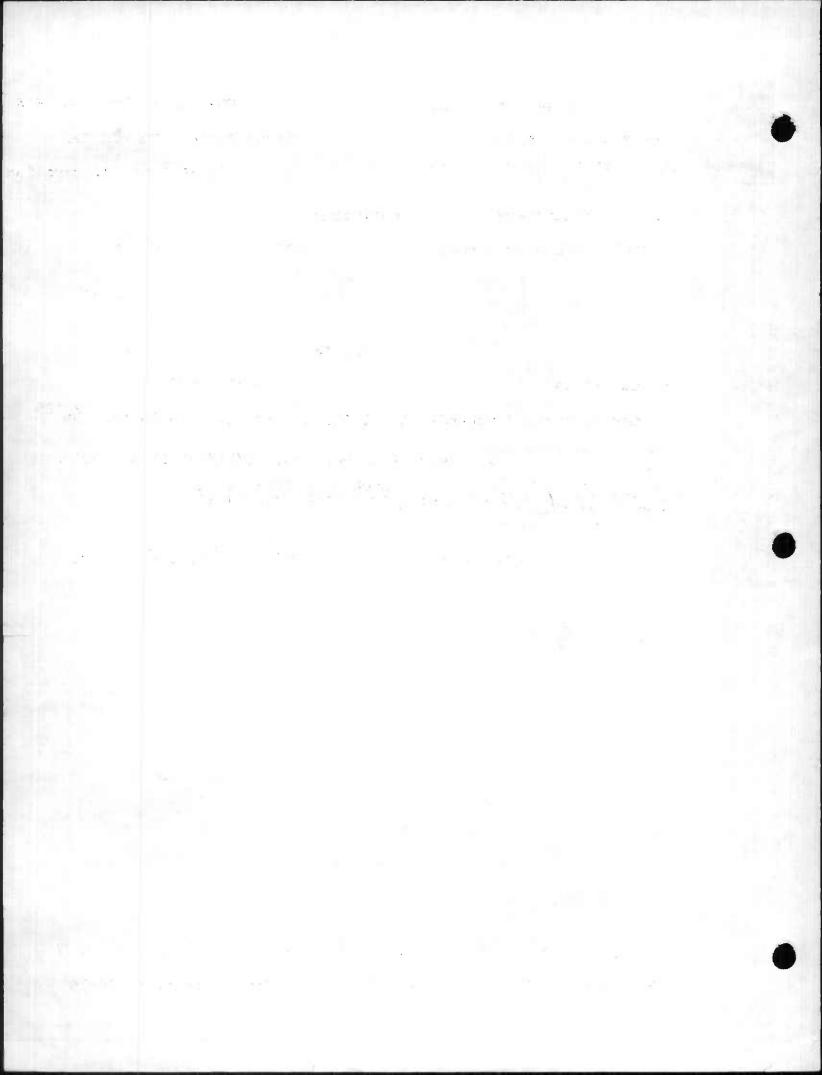


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State of Maryland / Department of Health and Mental Hygiene

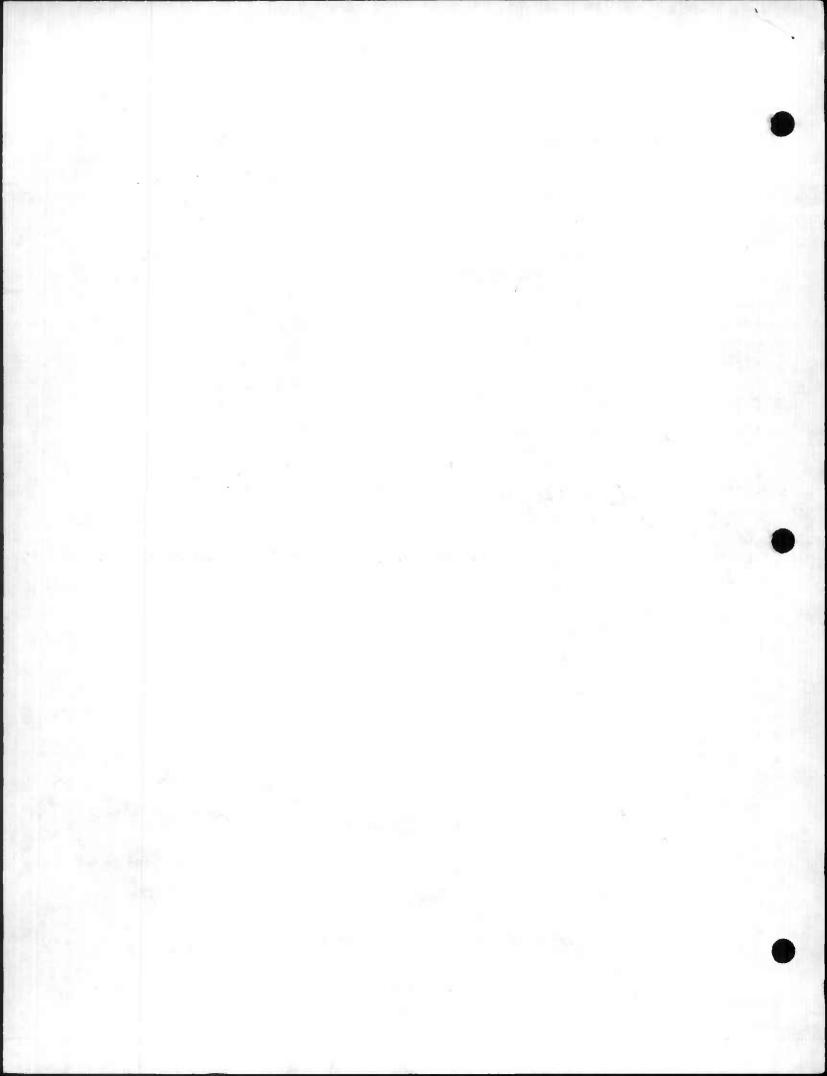
Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) **Physician** FEBRUARY 8, 1999 6:45 AN REVESTER PARKS /Medical 4e Fecitity Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring MONTGOMERY Hours Min. 8. Date of Birth (Month, Day, Year)

July 20,1928 5. Sociel Security Number 229-26-1516 If Under 1 Yeer 9. Birthplece (State or Foreign Country)
S. Carolir 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Months Deys 70 Yrs. Carolina Director Usuel Residence of Decedent with the Meryland 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumetic event, the Medical Examiner must be notified at MD Montgomery Kensington 1X Yes 2 □ No Director 10f. Zip Code 10g. Citizen of Whet Country? 10e, Street end Number 20895 U.S.A. 10701 Shaftsbury Street pemit. Pages 1 and 2 should be filed within 72 hours after death v
Department of Health and Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner research Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ♣ No If Yes, Give Yeer or Detes: 14. Rece - American Indien, Bteck, White, etc. Was Decedent of Hispantc Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education fy only highest grade completed) (Specify only highest grade Elementary/Secondary (0-12) College (1-4or 5+) 8th Housewife Home 18. Mother's Neme (First, Middle, Malden Sumeme) 17. Fether's Neme (First, Middle, Last) Myrtle Duffy Lester Wilks 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stele, Zip Code 0 8 9 5 19a. Informant's Neme/Retetionship (Type, Print) 10701 Shaftsbury St., Kensington, Chester R. Parks (Husband) 20b. Place of Disposition (Neme of cemetery, crematory or other plece) Dete 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Buriel 2 Cremetion 3 Removet from Stete 2/13/99 Silver Spring, MD Gate of Heaven Cem. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Eugeral Service Lice 22. Name end Address of Fecility
SNOWDEN FUNERAL HOME, P.A. 20850 ROCKVILLE, MD e, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, List only one cause on each line. Approximete Intervet Between Onset and Deeth **Physician** /Medical Immediete Ceuse (Finel disease or condition resulting in deeth) intra abdominal · adendo ercinomatosis Examiner Due to (or es e consequence of) Examiner the death certificeta be executed physician and the buriel-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or es e consequence of): 80 950 23b. Did tobacco use contributa to the cause of death? P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 8 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed has 1 Yes 2 No 1 ☐ Yes 2 ☐ No cartificate Hospital or Attending Physician: 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 9 2 ER/Outpetient 3 DOA this 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury et Work? Certification: 5 Pending Investigation 1- Naturat after death. 1 Yes 2 🗌 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours a 29a. Certifler 1🗹 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated. Medical (Check only one) 2 Madical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated. To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 34590 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) 1500 Forest Glen Rd., Silver Spring, MD 20910 Roy Fried, M.D. 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State FEB 1 0 1999 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

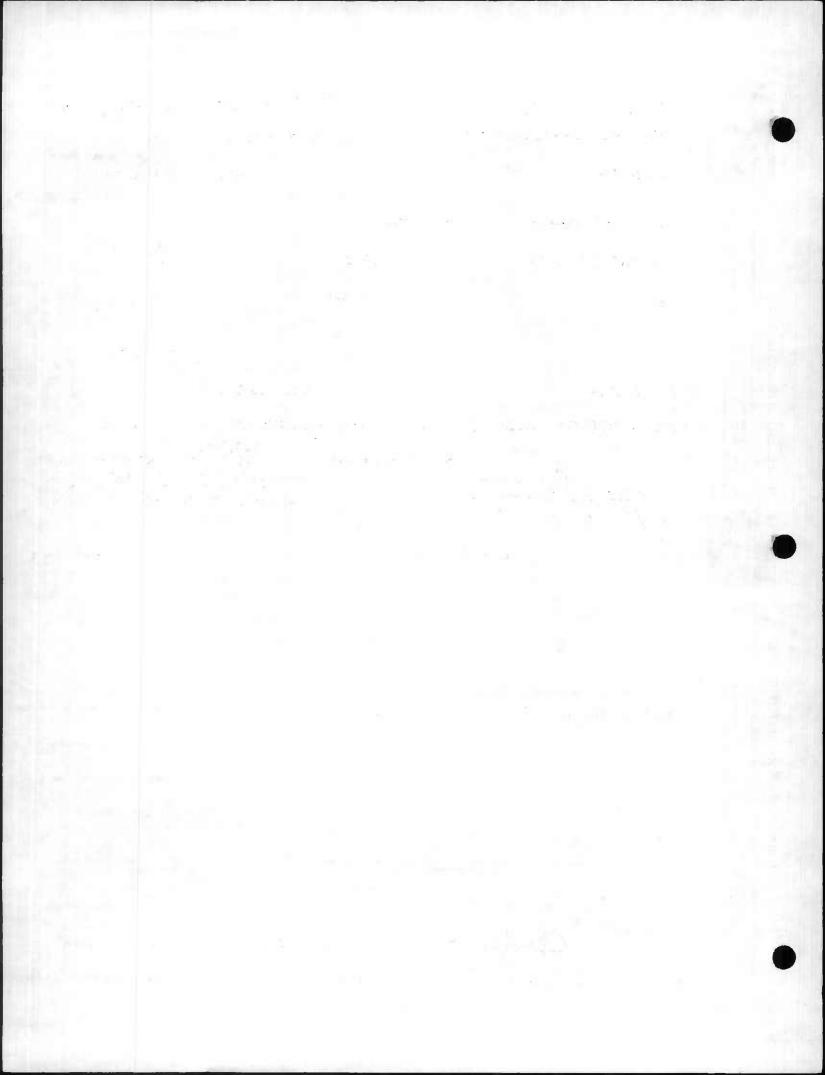
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State of Maryland / Department of Health and Mental Hygiene

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D	30. Nema end addrass of person who c Matthews Chacke Jo	omplated cause of death (I	tem 23e) (Type	Print)	h Caroline	Street	Baltimore	, Maryland 21287
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State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene

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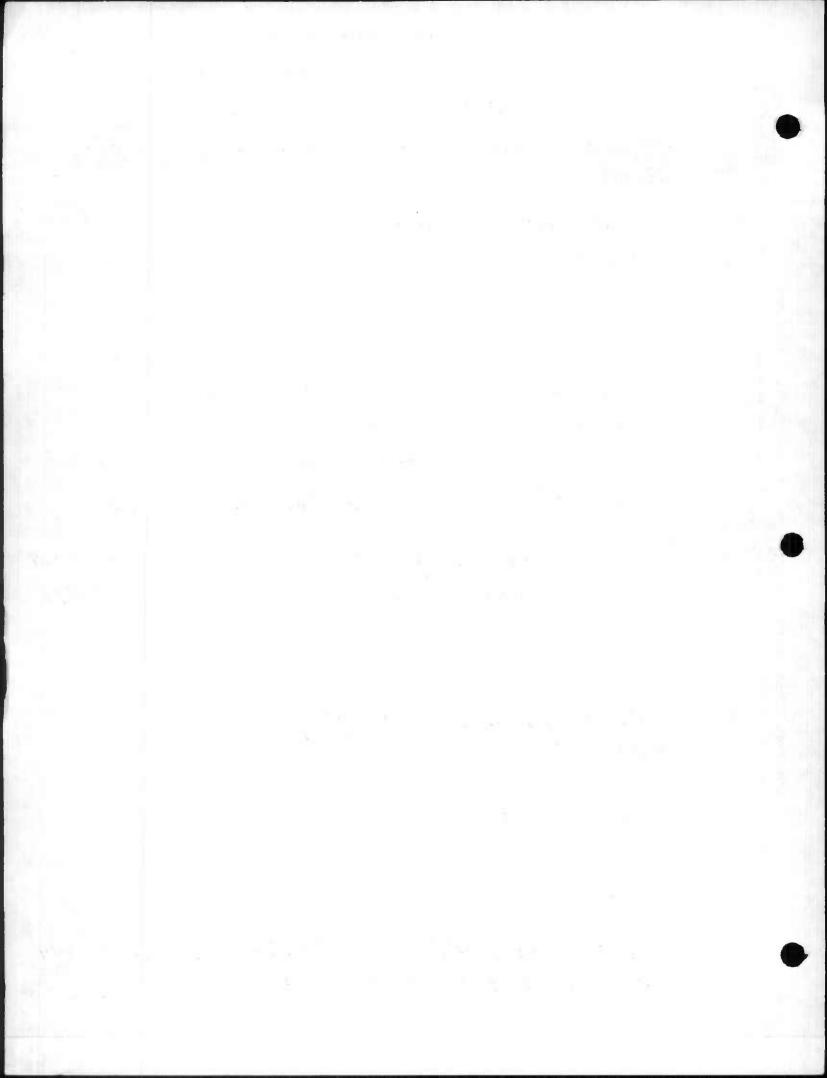
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

_			Certificate of De		05486
П	Physic	ian	Decedent's Name (First, Middla, Last)	2. Data of Death Month Day Yaar	3. Tima of Death
L	/Medi	cal	Margaret F. Pyke	February 7, 1999	8:55 AM
и	Exami	1er		city, Town, or Location of Death 4c. County of Death	
Ͱ	Funeral		5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) If Undar 1 Year If	OCKVIlle, MD Montg Undar 24 Hrs. 8. Data of Birth Jours Min. 8. Data of Birth (Month, Day, Year) 9. Bi	omery
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	A Mand		10a. Slata 10b. County 10c. City, Town or Location		10d. Inside City Limits
	Mar)	tor	Maryland Montgomery Gaithersburg		1 X Yas 2 No
	04 28 90 28	Director	10e. Street and Number 10f. Zip Coda	10g. Citizan of What C	ountry?
	23a MBL E	Funeral [408 Russell Avenue 20877	United Sta	tes
	ar de	nue	11. Marital Status 12. Was Decedent Ever in U,S. 13. Was Decedent of Hispa Armed Forcas? 13. Was Decedent of Hispa If Yes, specify Cuban, N	nlc Origin? (Specify Yas or No- laxican, Puarto Ricen, etc.) 14. Race - Am Black, Whi	
20	within 72 hours after death with the Maryland ere. than "natural", or items 23s or 23s-f show he Medical Examine: must be notified at	by F	1 □ Navar Married 2 ② Married 1 □ Yas 2 ② No If Yas, Giva 1 □ Yes 2 ② No S/ Year or Dates:	pecify: Specify:	
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Maryland 21215-0020	should b rid Menta marked	P P		Mary Blanche Shimer	
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9	Depa Impo any is		Rapp Funeral	l Services, P. A. enue, Silver Spring, MD 2	20010
			23a. Part1. Entar tha disaasa, or complications that ceusad the death. Do not anter the moda of dying, su shock, or haart failura. List only ona causa on aach lina.	ich as cardiac or respiratory arrast,	Approximata Intarval Batween
	Physician		*		Onsat and Death
	/Medical Examiner		Immadiata Causa (Final disease or condition rasulting in death) a. respiratory failure Dua to (or as a consequence of): b. Pheumonia		immediate 9days
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	outed	Examiner	Sequentially list conditions. b. Dua to (or as a consequence of):		1dlys
o,	e exection are larger and are larger		Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events		
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P. 0.	by the	hys	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in	40V- 00N- 200	robably 4 Unknown
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Records,	v require been si should I	ted	hunestensin		Wara autopsy findings available prior to
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Division	or Attending lefter death. Director: After	Certification:	3 ☐ Suicida 6 ☐ Could not be datarmined 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)	28f. Location (Straat and Number or R City or Town, Stata)	ural Routa Number,
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	Hosp 24 hor Fune stely fi	edical	29a. Cartifiar (Check only one) 1 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion one)	ata and place, and dua to tha causa(s) and mannar a n, daath occurred at tha tima, data and place, and du	s stated. a to tha causa(s)
	To the Hospital or Attanding Physician: which 24 hours after dealth as the Funeral Director: After this certific completely filled in by the funeral director,	Me	and mannar stated. 29b. Signature and titla of certifiar 29c. License nur	nbar 29d. Data signed (Mon.	th, Day, Yaar)
			1 / Kaul 1500 1 1 7,	1435 Felow	8.1909
	10	1	30. Nama and address of person who completel cause of daath (Itam 23a) (Type, Print)	on I si correctly	MA
			In Paul Kretting MV 2101 Medical	LYark Howe Silver	Mring 20902
	Sta Registr		31. Data filad (Month, Day, Year) J32. Ragistrar's Signatura G. Aogasto	/	



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ITEMS: #26,29D PER PHY G768 2-22-99 WR 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) GIOVANNA. FEBRUARY B5, 1999 PROVINI 7:49 PM 4a Fecility Neme (If not institution, give street end number) Saint Joseph Medical C 4b. City, Town, or Location of Death 4c. County of Deeth Center Towson Baltimore 8. Data of Birth (Month, Day, Year) Tan. 12, 19 If Undar 1 Year | If Under 24 Hrs. 7. Aga (In yrs. last birthday) 5. Social Security Number 6 Sex Birthpleca (Steta or Foreign Country) 10 M 20 F Months Deys Hours Min. 215-12-5318 Yrs. 1906 Maryland Usuel Residence of Decedant 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore 1 ☐ Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8513 A Heathrow Court 21236 USA 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas ᠌⊠No If Yes, Give Year or Dates: Was Decedant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Stetus Black, White, etc. 1 □ Navar Marriad 2 □ Married 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 17. Fathar's Neme (First, Middla, Last) 18. Mothar's Neme (First, Middle, Meiden Sumeme) Cesare Villa Roas Poggioli 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mr. Ferdinand C. Provini (Son) 9535 Elvis Lane Seabrook, Maryland 20706 20b. Placa of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 Buriel 2 □ Cramation 3 □ Ramovel from Stata Gardens of Faith Cemetery 2/9/99 4 Donetion 5 Other (Specify) Rossville Maryland 21. Signature of Funeral Service Licege 22. Neme end Address of Fecility Ruck Towson Funeral Home, Inc. 1050 York Road what 23a. Parti. Entar the disease, di complications that daused the deeth. Do not enter tha mode of dying, such as cardiac or respiratory arrast, shock, or heer feilure. List only one ceuse on each line. Approximata Interval Between Onset end Death CONGESTIVE HEART FAILURE 6 MONTHS Immediate Cause (Final disease or condition resulting in deeth) Due to (or as a consequance of): Sequentially list conditions, if eny, leeding to immadiate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequença of) Dua to (or as e consequence of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 38 Probably 4 □ Unknown 1 ☐ Yes 2 ☐ No 24b. Were eutopsy findings available prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Heme 5 ☐ Residence 6 ☐ Other (Specify) 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

physicien end the buriei-transit the death certificate be executed Box 68760 Physician/Medical 88 attending p the O signed by the Division of Vital Records, P. The lew requires that peed certificate has t director. or Attending Physician: this funeral After within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu Hospital

Physician

/Medical

Directo

Funeral

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Completed

Examiner

Funeral

Director

with the Meryland

parmit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Merylen Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other treumatic event, the Medical Examples must be notified as

Physician

/Medical

Examiner

Examiner

by

Completed

Be

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Certification:

Medicai

Baltimore, Maryland 21215-0020

1 Yes 2 27. Mapper of Deeth Valuret 2 Accident 3 ☐ Suicide 4 Homicide

29e. Certifie

(Check only one)

6 Could not be determined

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the besis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete and placa, and due to the ceuse(s) end menner stated. 29b. Signeture end title of certifie

29c. License number D32543 1

29d. Dete signed (Month, Dey, Year) 2-8-99

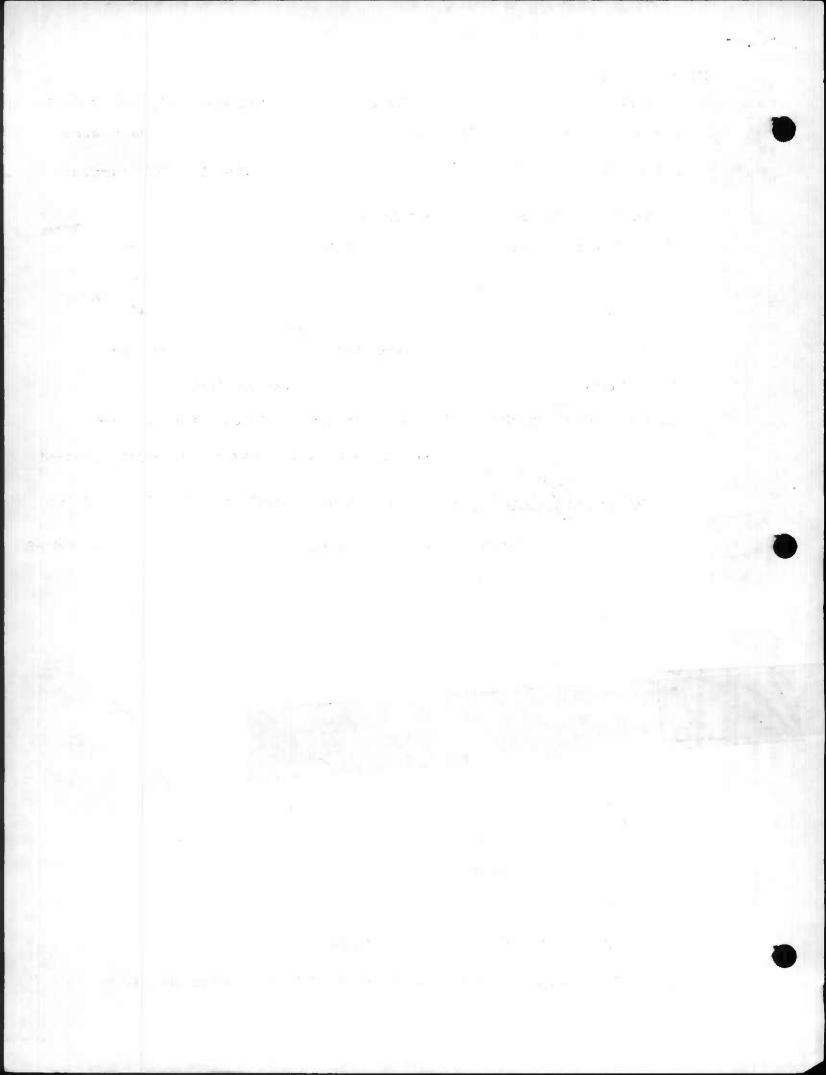
30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

MARK STROMBERG, M. D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

State Registrar 31. Date filed (Month, Day, Year) 1999 FEB 22

32. Registatr's Signeture

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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Daath 3. Time of Death 1. Decedant's Name (First, Middle, Last) Physician 0 /Medical 4c. County active Nama (If not institution, give streat and number) 4b, City, Town, or Location of Daeth Examiner HOSPITAL WESTMINSTER ARROLL (TENECAL oun7 1 Year If Undar 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foraign Country) Security Number 6. Sax **Funeral** 212-18-346 Months Days 1 2 M 2 □ F Yrs. Director Usual Rasidence of Dacedan 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits show x 28a-f show a notified at 1 ☐ Yas 2 ☐ No BALTIMORE Director 10f. Zip Code 10g. Citizan of Whet Country? 10e. Street and Numbe permit. Pages 1 and 2 should be filed within 72 hours after death with: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other treumatic event, the Medical Examinet must be in page. USHFuneral 12. Wes Dacedent Evar in U,S. Armed Forcas? 1 ☐ es 2 ☐ No Race - American Indian, Black, White, atc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxicen, Puarto Rican, etc.) 11. Marital Status 1 Naver Married 2 Marriad 1 Yas 2 No Specify: WHITE Specify Year or Dates: WWII þ 3 ☐ Widowad 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Spacify only highast grada complated) Elemantary/Secondary (0-12) College (1-4or 5+) 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middle, Last) Be ADAM VIOLA KITTER 19a. Wiformant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) BALTIMORE MD 21236 3907 HANNON CT 2F OROTHY WIFE 20b. Place of Disposition (Nama of cemetary, cramatory or other place, 20a. Mathod of Disposition Dete 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremetion 3 DRemoval from State 4 □ Donetion 5 □ Othar (Specify) ne and Address of Facility IS FUNERAL HOME ! Chapel, P.A. 21. Signatura of Puneral Service Li 112 WASHINGTON RD., WESTMINSTER, MD. 21157 caused the death. Do not anter the mode of dying, such as cerdiec or respiratory arrest, Part1. Enter the disaese, or complications that caus shock, or failure. List only one cause on aach Approximete Interval Batween Onset and Death **Physician** Emboli (probable) Immediate Cause (Final disaasa or condition rasulting in daath) /Medical Examiner Due to (or as a consequence of) Examiner CUD attending physician and for use as the bunal-transit Sequentially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Disaasa or injury that initiated avents rasulting in daath) Last Due to (or as a consequence of) Physician/Medical Due to (or as e consequence of): 98 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. signed by 1 Yes 2 No 3 Probably 4 Unknown þ cate has been sig , page 2 should b 24b. Ware autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? Completed certificate has 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was cese refarred to medical examinar? Be 26. Placa of Daath (Check only ona) TOF Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yes 2 No 1 Inpatiant 2 ☑ ER/Outpatient 3 ☐ DOA After this funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? Certification: 5 Panding invastigation 1 Natural 1 Yas 2 No 2 Accident the 6 Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) filled in by 4 Homicida 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifiar (Check only one)

requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending r death. after deatl To the Hospital within 24 hours completely

death with the Maryland

Baltimore, Maryland 21215-0020

31. Data filed (Month, Day, Yaar)

29c. License number

29d. Date signed (Month, Day, Year)

29b. Signeture and title of certifier millet

30. Name and address of person who complated cause of death (Item 23a) (Type, Print)

leton Poole

21157

State Registrar

FEB 0 9 1999

32. Registrar's Signatura

teles ven a tiel de la latin name en la ci The state of the s top it is back made Personal Property of the Section of The state of the s Lore hare. "It the stay South Aires ATTION PARKS VIEW AND ALL AND ENGINEER FRANCE CONTRACTOR OF A STANDARD OF A MA telegraphic or the peak of the company of

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RI	Physicia	n	1. Decedent's Name (First, Middle, Las			Rega		OI.	Dealii	Month	2. Date of Death Month Day Year FEBRUARY 3, 1999 4:55			
	/Medica Examine	r	4a Facility Name (If not institution, give CARROLL COUNTY GET		ber)		7 00		4b. City, Town, or L WESTMINST		th	4c. County	y of Death	
Ī	Funeral Director		5. Social Security Number 6. Se		. Age (In yrs.	last birthdey) Yrs.	If Under 1 Months 2	Yea Days		8. Date of Bi (Month, D Nov . 16	irth ay, Yea	ar) 998	9. Birthplace Country) Maryla	e (State or Foreign
	Aarylend I show	0	Usual Residence of Decedent 10a. State 10b. County Md. Carroll			y, Town or Lo							10d.	Inside City Limits
	with the N a or 28a-1 be notifi	Director	10e. Street and Number		EIO	dersbu	10f. Zip C				10g. Citizen of What Country		What Country	
020	n 72 hours after death with the Manylend "natural, or flems 23s or 28s-f show edical Examiner must be notified at	by Fur	2016 Conan Doyle 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Da	ces? 2 📉 No		21784 13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: Specify: With the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specify of the specific of the sp							ndian,
121	C 9	Completed	15. Decedent's Ed (Specify only highest grant Elementary/Secondary (0-12)	lucation		(Give	dent's Usuai kind of work DO NOT use	done	e during most of work	king	16b.	Kind of B	usiness/Indus	ry
Maryland 2	d off	10 26 00	0 17. Father's Neme (First, Middle, Last) Brendan P. Regan				none		18. Mother's Nem					
Baltimore, Ma	Pages 1 and nant of Health int: If Hem 27 ary or other tr		19a. Informant's Name/Relationship (Type, Print) Brendan P. Regan/Father 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22a. Name and Address of Facility 25a. Print Information and Grant Printing the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest,											State
Ba	permit. Departr Importa any inju													proximete
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)		JDDEN IN		ATH SYND						In Or	erval Between nset and Deeth
60,		il Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.											
Box 68760,	certificate be axec nding physician an usa as the bunal-tr	VMedic	that infliated events resulting in death) Last Due to (or as e consequence of):											
P.0.		/ Physician/Medical	Part II. Other significant conditions co	ontributing to dea	ath but not res	sulting in the u	inderlying cau	use ç	given in Part I.				ontributa to th	e cause of death
Records,	5 5 4	Completed by								24a. Wa	s an au formed	utopsy !?	availa	autopsy findings ble prior to letion of cause
Vital F	iclen: The la cartificate ha rector, pega	0	25. Was case referred to medical					+	26. Place of Dea		one)	2 □ No	1 CY	es 2 No
1 <	2 0	0	examiner? 1 ☑ Yes 2 ☐ No			ER/Outpaties	nt 3 DOA	0	hther: 4 \substitute Nursing H			8 🗆 Ot	her (Specify)	
sion of	Ing After Iune	entification:	27. Manner of Death 1 🖾 Natural 5 🗆 Pending investigation	1	Injury , Day Year)	28b. Time o Injury	M 284		ury at ork? □ Yes 2 □ No	28d. Describe	how in	njury occu	rred	
Division	or Attend after death Director: /	erill.	3 Suicide 6 Could not be determined	286. Place	of Injury - At hig, etc. (Specif	ome, farm, str	reet, factory,	office	8	28f. Location City or To			ber or Rural R	oute Number,

To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this cartificate h completaly filled in by the funeral director. pega Medical Certification: To

29a. Certifier (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) FEBRUARY 4, 1999

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

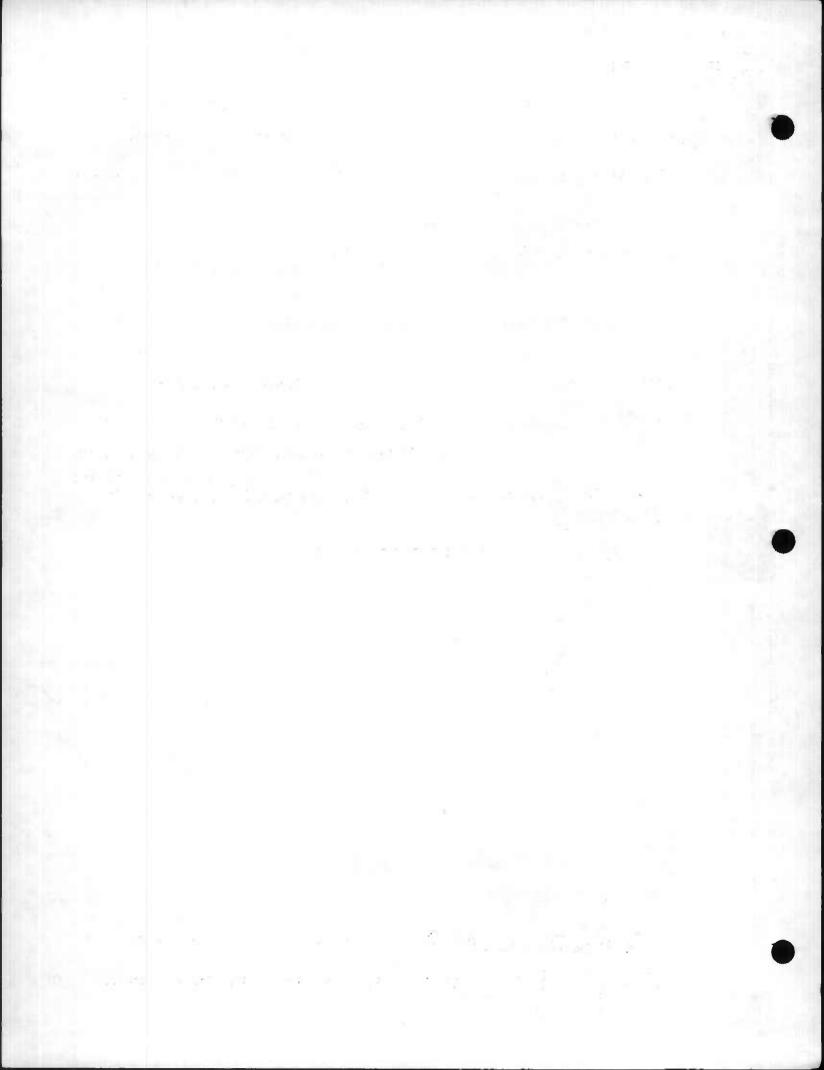
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111 Penn Street, Baltimore, Maryland 21201

State Registrar

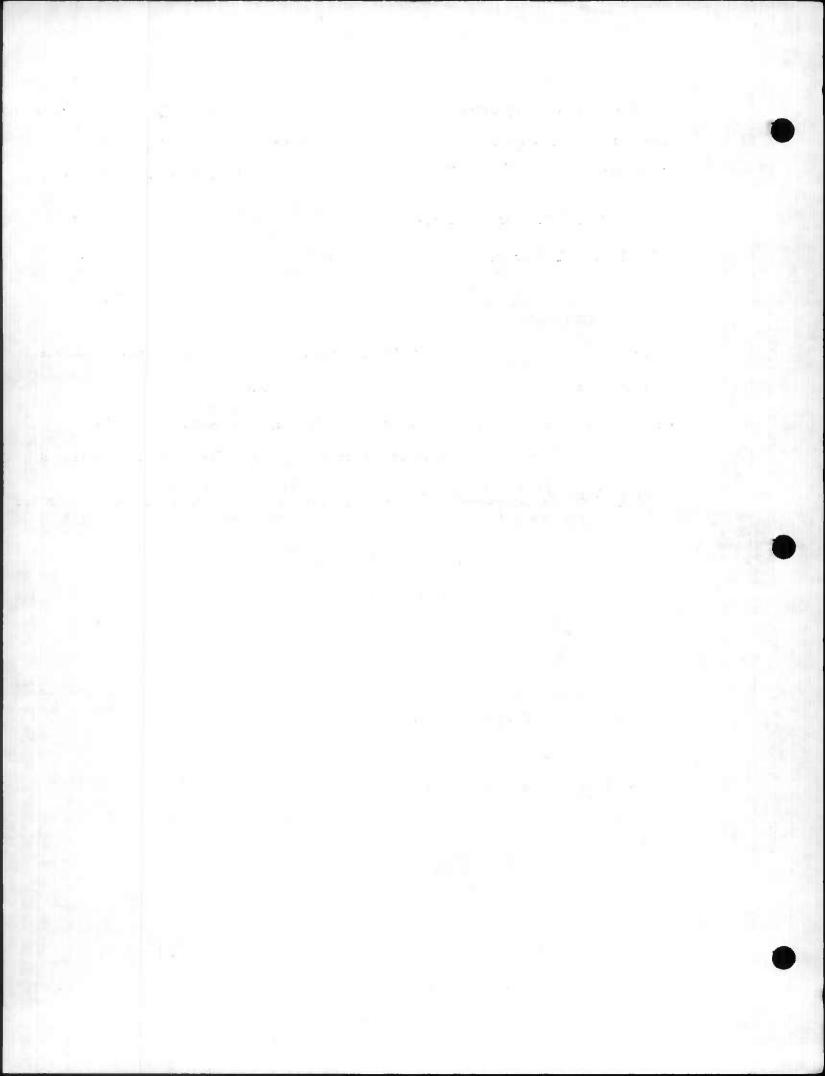
FEB 0 5 1999

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

		nte of Death	Reg. No.					
Physician	Decedent's Name (First, Middle, Last)	N.	Date of Deeth Month Day Year 3. Time of Death					
/Medical	RUBY REYNOLDS		02 10 99 1/31					
Examiner	4a Facility Name (If not institution, give street and number)	4b. City, Town, or Locatio						
·	Laurel Regional Hospital	Laurel	Prince Georges					
Funeral Director	579-05-8749 1 M 2 XF 86 Yrs. Month	ler 1 Year If Under 24 Hrs. 8. C s Days Hours Min. 0	Date of Birth Month, Day, Year) ec. 4, 1912 9. Birthplace (State or Foreign County) Virginia					
P >	Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location		10d. Inside City Limits					
eh/re ehov			1⊠Yes 2□No					
r 28a-f ehow	Maryland Prince Georges Laurel		**					
death with the Merylend ms 23a or 28a-f show rmust be notified at	10e. Street and Number 14200 Laurel Park Drive	Zip Code 20707	10g. Citizen of What Country? United States					
of the state of th	11. Maritel Status 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 Mo If Yes, Sive Yeer or Dates:	tedent of Hispanic Origin? (Specify becify Cuban, Mexican, Puerto Ricer 2 No Specify:	Yes or No- n, etc.) 14. Race - American Indian, Bleck, White, etc. Specify: Black					
72 hours	15. Decedent's Education 16a. Decedent's Ut (Specify only highest grade completed) (Give kind of the completed)	ual Occupation	16b. Kind of Business/Industry					
within within than the	Elementary/Secondery (0-12) College (1-4or 5+)	work done during most of working use retired)						
d withir giene.	12 Cafeter	ia Manager	D.C. Public Schools					
of filed and a filed a	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)						
should be an american marked of mark	William Reid	Lillian Payne						
Maryland d 2 should be file th and Mentel Hy 7 is marked oth traumatic event		ss (Street and Number or Rural Ro	oute Number, City or Town, State, Zip Code)					
Magnith are traver traver	George W. Reynolds Son 11720 Br	ight Passage, Co	lumbia, MD 21044					
Paltimore, Maryland 212: permit. Peges 1 and 2 should be filed within Department of Health and Mentel thygiene. Important: if them 27 is marked other than ange. To Re Comp	20a. Method of Disposition 1	/ame of De	ate 20c. Location - City or Town, State 5/99 Suitland, Maryland					
Physician /Medical Examiner	23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mishock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Septic Shock Due to (or as a consequence of	ode of dying, such as cardiac or res	W., Washington, D.C. 2001					
Box 68760, death certificate be executed e ettending physician end id for use es the buriel-transit								
. 0 00 7	Part II. Other significant conditions contributing to death but not resulting in the underlying	ceuse given in Part I.	23b. Did tobacco usa contribute to the cause of death?					
d by detect	Multin faret domentia		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown					
aw requires been size been	Swallowing disorder		24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of ceuse of death?					
The I	Parkinson's disease		1 ☐ Yes 2 MS No 1 ☐ Yes 2 ☐ No					
VITAL IN SICIAN: The certificate irector, pag		26. Plece of Death (Ch	heck only one)					
Of VItal Ho Physician: The I this certificate he rel director, page		Othor	5 Residence 8 Other (Specify)					
Jing Ph. After thi funeral			Describe how injury occurred					
DIVISION I or Attending sefter deeth. I Director: After d in by the fune	3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, fact building, etc. (Specify)		Location (Street and Number or Rural Route Number, City or Town, State)					
DIVISION Control of the Hospital or Attending P within 24 hours effer deeth. To the Funeral Director: Affer to completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurre (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurre (Check only one)	ad at the time, date and plece, end on, in my opinion, death occurred a	due to the cause(s) and manner as stated. It the time, date end place, and due to the cause(s)					
ro th within Fo th		29c. License number	29d. Date signed (Month, Day, Year)					
5	Mark D Goldman mo	122123	2/10/99					
11.5	30. Name and eddress of person who completed ceuse of death (Item 23a) (Type, Print) MARK D. GOLDMAN MD 8317	Cherry Cane	, Lawel Md. 2070					
State Registrar	31. Date filed (Month, Dey, Year) FFB 1 2 1999 32. Registrar's Signature	parket						

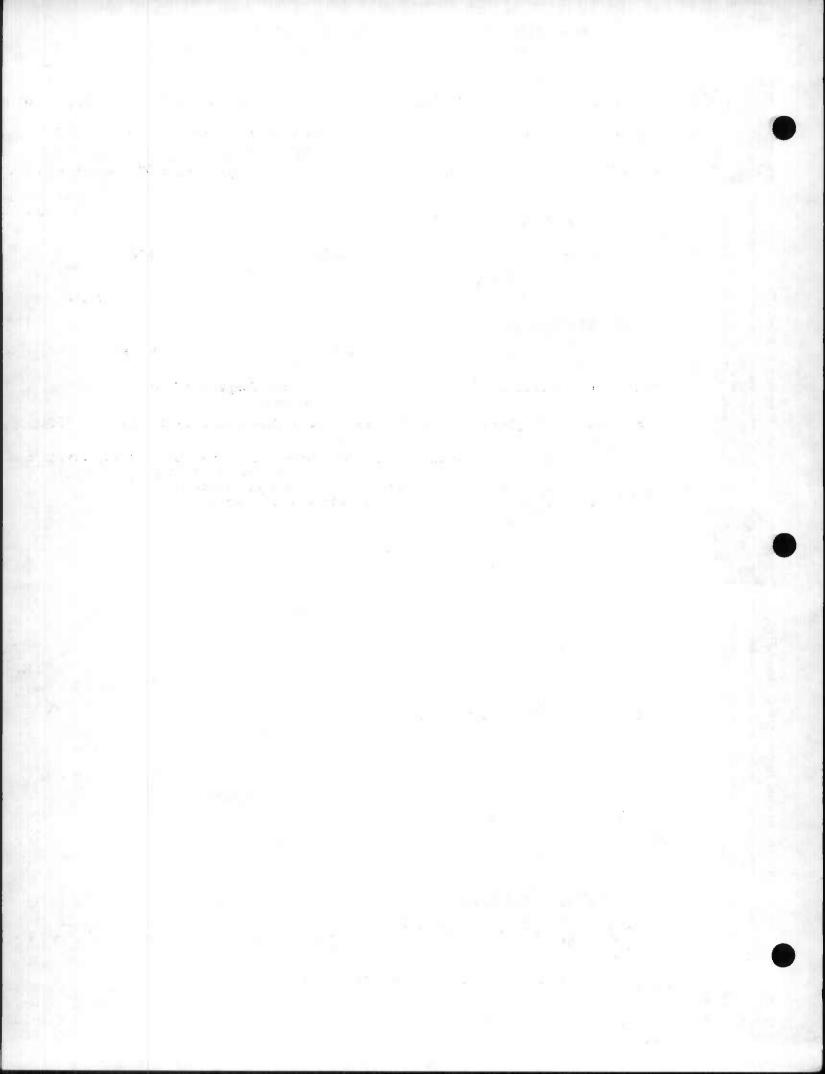


State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Q PALL **Physician** RITTER 1:30 PM February JOSEPHINE 1999 /Medical 4b. City, Town, or Location of Death, 4c. County of Deeth 4a Facility Name (If not institution, give street end number) BALTIMORE. RANDALLSTOWN HOSPITAL CENTER MORTHWEST Hours Min. 8. Date of Birth (Month, Dey, Yeer)
Sept. 27, 1 7. Age (In yrs. lest birthday) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 M 2 X F 224-03-3507 96 West Virginia 1902 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mantal hygiena. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Carroll Sykesville 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 7200 Third Avenue 21784 USA Funeral 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Bleck, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married 1 Yes 2 No Specify. Specify: White by 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Angelo Giuseppe Cometti Eva Josephine Duey 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Norman Olsen (nephew) 4220 Scarlet Sage Court, Ellicott City, MD 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition Dete 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2/11/99 4 Donation 5 Other (Specify) Metropolitan Crematory Alexandria, Virginia 22. Name end Address of Facility Francis J. Collins Funeral 21. Signature of Funeral Service Licensee 500 University Blvd. West Home, Inc. Silver Spring, MD 20901 Uben Dones 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediete Cause (Final disease or condition resulting in death) AINOMUSINT Examiner Due to (or as a consequence of) Examine physician and requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Physician/Medical Due to (or es e consequence of): 98 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown PANCREATITIS. by should b 24b. Were eutopsy findings available prior to 24e. Was en eutopsy Completed completion of cause of death? The lew hes page 2 : 1 ☐ Yes 2 ☐ No certificate Division of Vital Physician: To Be 25. Was cese referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1□Yes X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this funaral 28d. Describe how Injury occurred s efter death.

I Director: After the in by the funara 27. Menner of Deeth 28b. Time of 28c. Injury at Work? Certification: 1 Natural
2 Accident or Attending 5 Pending Investigation 1 Yes 2 No 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours e To the Funeral Complately filled edical 29a. Cartifier 1 🔁 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) and menner es stated. 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end piece, end due to the ceuse(s) and manner stated. (Check only PHYSICIAN 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature ditte of certifier HOUSE 42723 FEBRUARY 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARISIT .5401 Old Court Road VERAHALLII Randallstown, Mb 31. Date filed (Mos 32. Registrar's Signature

State Registrar



State of Maryland / Department of Health and Mental Hygien®

					Ce	rtifica	te of	Death			Reg. No.							
Physicia	1. Decadent's Neme (/	First, Middle, La								2. Date of De Month	eeth Dey	Yaar	3. Time of Deeth					
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Examine		ot institution, giv Cromwe 1.						Bethe		1	rv							
Funeral	5. Social Security Num				rs. last birthdey		er 1 Year	If Undar	24 Hrs.	8. Data of Bir (Month, De		-	-					
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Physician /Medical	Immediate Cause (Fin	al										- 1						
Examiner	diseese or condition resulting in death)		a		ver Ca	-2710	41						6 weeks					
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To the Hospital or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this cartificate ht completely filled in by the funerel director, page	29a. Certifier 1		niner: On the b															
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30	Description Description Description Pebruary 9,									1999								
,	30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)																	
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State Registra		B 10 19	199	Registrer's Sig			lon 1											
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Nama (First, Middle, Last) 3. Tima of Death 2. Data of Death Month FeBRUARY 14c. County of Death 355 PM Kussell, ELMER JUNIOR IIMOTHY 4a Facility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Death SPRING SHARON NURSING HOME MONTGOMERY DANDY If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) Months 180 M 2□ F Yrs. 88 577-20-9175 Dec. 6. 1910 North Dakota 10e State 10b County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Silver Spring 10f. Zip Coda Maryland | Montgomery 10e. Street and Number 10g. Citizan of What Country? 3221 Ludham Drive 20906 13. Was Decedant of Hispanic Origin? (Specify Yes or NoIf Yas, specify Cuban, Maxican, Puarto Rican, atc.) U.S.A. 14. Race - Amarican Indian, 12. Was Decedent Ever in U,S. Armed Forcas? 1 13 Yas 2 □ No If Yas, Give Yaar or Datas: 11. Marital Status Black, Whita, atc. 1 Never Married 2 Married 1 Tas 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White WWIT 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast greda complated) Elementary/Secondary (0-12) College (1-4or 5+) Finance Financial Management 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Neme (First, Middla, Meidan Sumema) Timothy E. Russell, Sr Lucy Morkert 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) (nephew) 3440 Amou. 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 3420 Knox Road Annandale, Virginia 22003 Date 20c. Location - City or Town, State Mark S. Russell 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ☑ Other (Specify) Entombment Gate of Heaven Cemetery 02/8/99 Silver Spring, Maryland 21. Signatura of Funeral Sarvice Licansee 22. Nama and Addrass of Facility Francis J. Collins Funeral Home, Inc. Kein Skiles 500 University Blvd., W., Silver Spring, MD 20901 23a. P t/ Entar tha disaasa, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona causa on aach lina. Approximate Intarval Batween Onsat and Death Immediata Causa (Final . VENTRICULAR ARRHYTHMIA MINUTES diseesa or condition resulting in deeth) Due to (or as a consequence of): COLONARY ARTERY Due to (or as a consequence of): DISEASE Sequantially list conditions, if eny, laading to immadiata causa. Entar Undarlying Ceuse (Diseese or injury that initiated avents rasulting in death) Last Dua to (or as a consequanca ot) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 3 Probably 4 ☐ Unknown 1 TYes 2 No. CONGESTIVE HEART FAILURE; ATRIAL FIBBL-24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Wes case refarred to medical axaminar? 26. Place of Daath (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 28a. Data of Injury (Month, Day Yaar) 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? 5 Pending invastigation 1 Naturel 1 ☐ Yas 2 ☐ No 2 Accidant 3 ☐ Suicida 6 Could not be determined 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 Homicide

attending physician end for use as the bunel-transit law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, signed by the a certificate has b Hospital or Attending Physician: 24 hours efter death.
Funeral Director: After this certificately filled in by the funeral director. To the Hospital or within 24 hours aff To the Funeral DI completely filled in

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Director

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permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Marylen Department of Health end Mental Hygiene.
Important: if Item 27 is marked other than "natural", or items 23s or 28e-f show say hylury or other traumatic event, the Medical Evantmet must be notified at encited.

Physician /Medical

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Physician/Medical

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Certification: To

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Baltimore, Maryland 21215-0020

LATION; DEMENTIA OF THE ALZHEIMER'S TYPE

27. Menner of Deeth

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and titla of certifier

29c. Licanse number

29d. Date signed (Month, Dev. Year)

ATTENDING PHYSICIAN

TEBRUARY

30. Nama and eddress of person who complated causa of death (Itam 23a) (Type, Print)

20860 GRACE BROOKE HUFMAN, M.D. 18100 SLADE SCHOOL ROAD SANDY SPRING MARYLAND

State Registrar 31. Data filed (Month, Day, Year) FEB 08

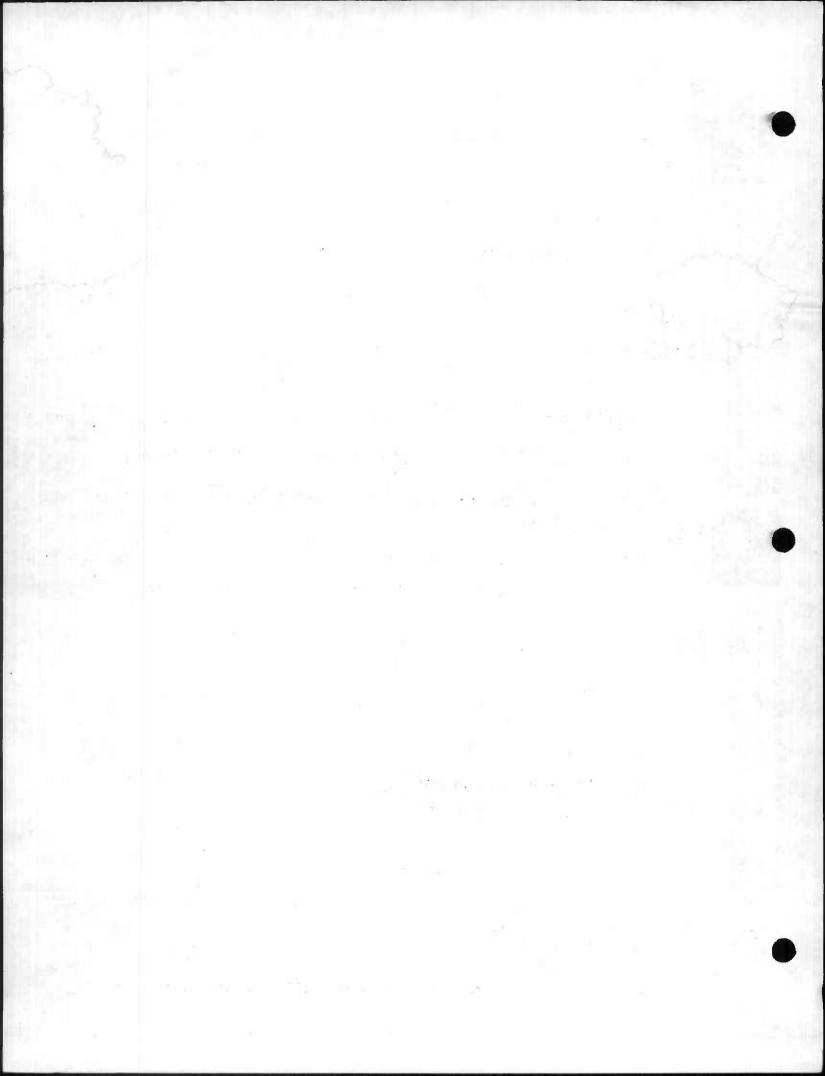
32. Ragistrar's Signatura

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Physician	1. Decedent's Name	and the second second	Last) E. RUS	חיד אז	301	tificate of	20411	2. Data of D Month Feb		Year	3. Tima of Death		
/Medical Examiner	4s Fscility Nama (f.	f not institution,	give street and nu	ımber)				, or Location of Dea	th 4c. Count	999 y of Death	6:25 Am		
			rsing C					umbia	How	ard	2		
eral ctor	5. Social Security N 216-16-	-0300	3. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. 76	last birthday) Yrs.	ff Under 1 Yaar Months Days	If Undar 24 Hours	Min. A Data of Bi	1,1922	9. Birthr	place (State or Foreign Tyland		
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	1X Buriat 2		☐Removal from	State	emetery, cren	natory or other place			9 Laur				
BOC#.	21. Signature of Fu 23a. Part T. Enter II shock, or hear	2085 Vill	O e , Md Approximata Interval Batween										
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tlon	1 ⊠Natural 2 ☐ Accident	5 Pending investigation	ion	of Injury oth, Day Year)	Injury	28c. Injur Wor M 1 🗆	k?` Yes 2⊠No	12.00	1/A.	,,,,,			
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S	4 LI HOMBOOD		Dulio	ing, etc. (Specif)	N/A.				1/A.				
Medical Certification	29a. Certifier (Check only one)	1⊠ Certifying 2☐ Medical Ex	aminer: On the b	a best of my know easis of examinal oner stated.	viedge, death ion and/or inv	occurred at the tire estigation, in my o	na, date and p pinion, deeth	place, and due to the occurred et the time	cause(s) and m date and piece	anner es s , and dua t	stated. o tha cause(s)		
W	29b. Signature and	title of certifier	00- 2	1	_	29c. Licens	e number		29d. Data signe	ed (Month,	Day, Year)		
	P/V7	> Clas		12		D 30	469.		February	9,	1999.		
State egistrar	30. Nama and addra N B Vellar 31. Data filed (Mont	nki, MD;	9055, (t Driv			Ellicott	City, M	D 210)42.		

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Kutherford Month February (0 1., 90 025 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Shady Grove Adventist Hospital Rockville

Sciel Security Number 6. Sex 17. Age (In yrs. lest birthday) Months Days Hours Min. 8. Montgomery 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Days Yrs. 51 579-62-4516 December 29, 1947 Washington, D.C. Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Maryland Montgomery Rockville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1115 Allison Drive 20851 United States 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 N Married 1 X Yes 2 □ No Specify: 3 ☐ Widowed 4 ☐ Divorced Mexican Hispanic 16e. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry National Institutes Elementery/Secondery (0-12) College (1-4or 5+) of Health 5+ Cytoimmuno Chemist 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Surneme) Raul Vasquez Angelina Gonzalez 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) R. Ward Rutherford/Husband 1115 Allison Drive, Rockville, Maryland 2085 ce of Disposition (Neme of 2000) 20c. Location - City or Town, Stete 20b. Place of Disposition (Neme of cemetery, crametory or other place) February 10, 1999 20a. Method of Disposition 1 X Burial 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Gate of Heaven Cemetery Rockville, Maryland 21. Signature of Funeral Service Ocens 22 Name end Address of Fecility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M00846 23a. Pert 1 Enter the disease, or complicet insituations that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one a use of each line. Approximete Intervel Between Onset end Deeth minutes Immediate Cause (Final disease or condition resulting in deeth) Kupture of Myocardium myocardial Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of) hma Due to (or es e consequence of) 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 24a. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 Yes 1 ☐ Yes > No 26. Place of Deeth (Check only one)

Physician /Medical **Examiner**

pue

attending physician

peeu

certificate

neral Director: After this filled in by the tuneral di After this

To the Hospital or within 24 hours aft To the Funeral Di

use as the burial-tran

Department of Important: If any injury or

Physician

/Medical

Examiner

Directo

Funeral

ρ

Completed

Be

Funeral

Director

Berns 23a

the Medical Examiner

Pages 1 and 2 should be illed within 72 hours attartment of Health and Metall Hygiene.
Intil Nem 27 is marked other than "natural", or lite
any or other traumatic event, the Medical Examine

Baltimore, Maryland 21215-0020

the Maryla 28a-f shov ns 23a or 25a-f sho must be notified at

> Physician/Medicai signed by the atter Be P

or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

þ Completed Certification: 1 Naturel 2 Accident 3 ☐ Suicide 4 - Homicide

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Wes case referred to medical Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 1 Yes 2 Note 1 ☐ Inpatient 2 ZNER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 1 ☐ Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.
2 ☐ Medical Examiner: On the bests of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the ceuse(s) end menner stated. 29e. Certifier 29b. Someure end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year)

30. Name end eddress of person who comple

Medical

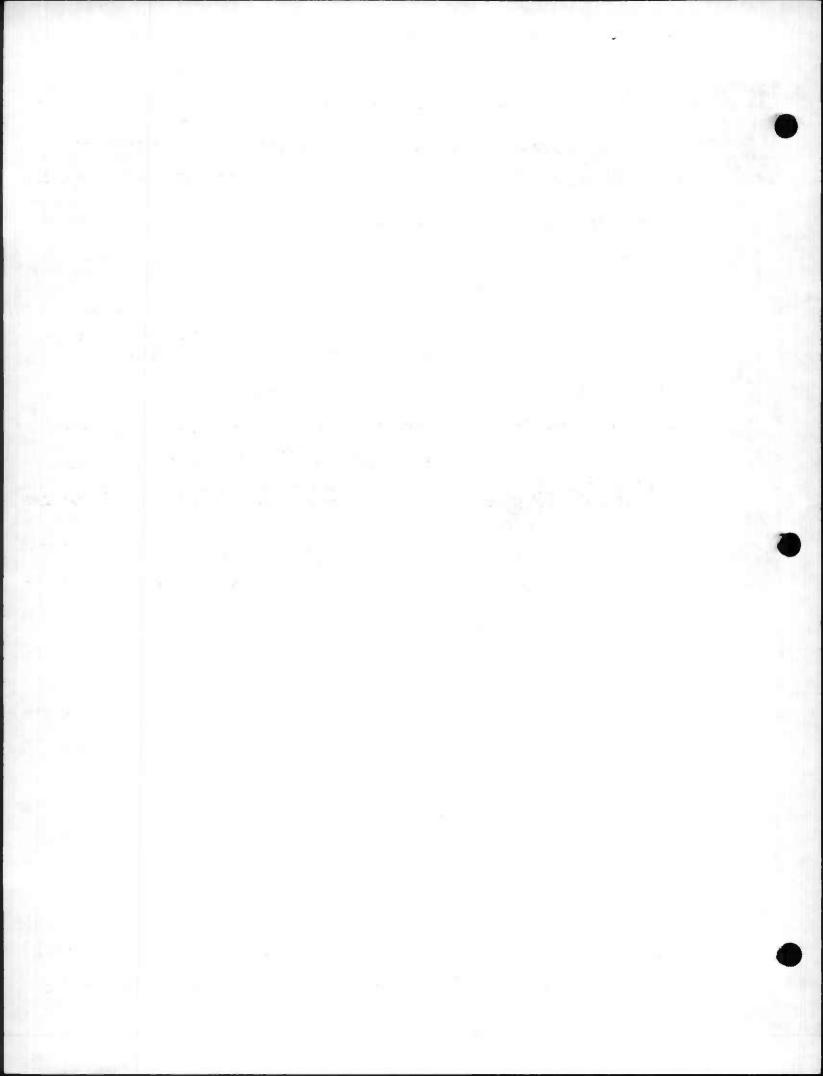
7 31. Dete filed (Month, Dey, Year) State FEB 09 Registrar

32. Registrer's Signeture

ed cause of deeth (Item 23a) (Type, Print)

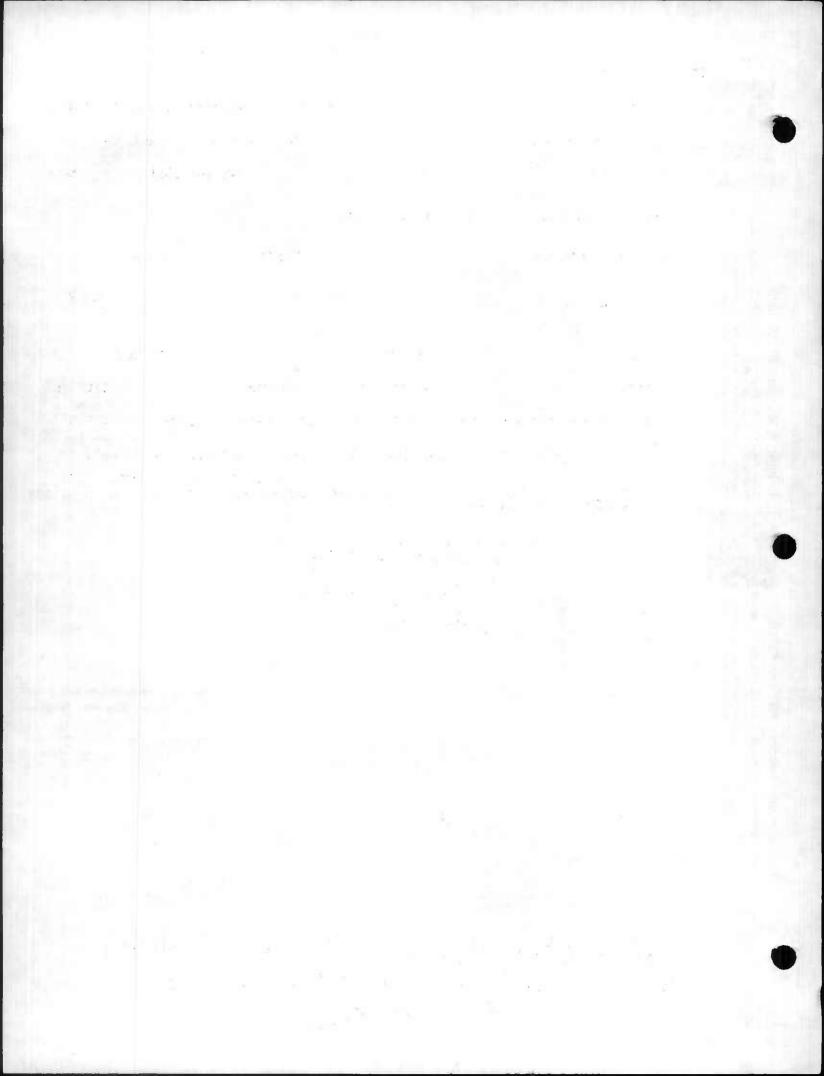
medical Center Dr. Rockville, md

DHMH 16 Rev 6/95



	ITEMS: #26 PER F.H. G768 2-22-99 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Day Year											Vac-	3. Time of D	
sician edical	ISAA	С	IRVI	N	F	ROSEN	BERG	5		FEBRUA			8:45 A	
iner	4a Facility Name (If	The Tall of the Party of the Pa		umber)			4	lb. City, To	wn, or Lo	ocation of Dea	th 4c. Cou	nty of Deeth		
	4043 CA			1		If I Indo	1 Year	RAN If Under		LSTOWN		LTIMOF		
	5. Sociel Security Nu 216–28–7		S.Sex XXM 2□ F	7. Age (In yrs.	67 Yrs.	Months	Days	Hours	Min.	8. Date of B (Month, D MAY 18	ay, Year) 1931	9. Birth	place (State or F ntry) MD	
	Usual Rasidance of	Decedent									,			
	10a. State MD	10b. County BALTI	MODE	10c. Ci	ty, Town or Loc RANDAI		TATAT						10d. inside City 1 ☐ Yes 2	
	10e. Street and Num		. IORE		TURIDIN	10f. Zip					10g. Citizen	of What Cou		
-	4043 CA		ROAD.			1000	, 6040	21	133		U.S		,	
	11. Maritel Stetus	I TIMIOD		cedent Ever in U	l,S. 13. V	Ves Dece	dent of H			ecify Yes or N Rican, etc.)		laca - Ameri		
	1 ☐ Never Marrie			2 No Give		☐ Yes		Specify:		rican, etc.)	Spe	llack, White	VHITE	
	(Speci	15. Decedent's	Education grade completed	4)	16a. Deced	kind of wo	rk dona d	du <i>rina</i> mos	t of work	ina	Business/ir	siness/industry		
	Elementary/Secon		-	(1-4or 5+)	lifa. D	OO NOT u	sa ratired	1)						
	12 17. Father's Name (First, Middle, La	est)		GROCE			18. Mothe	er's Name	e (First, Middle	GRO e, Maiden Sum	CERY		
	SAMUEL				ROSENI	BERG		PAU	JLIN	E		I	LICHTER	
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural CVNTPUTA DOSENIBEDS / DATICUTED 6719 OF DEMILICO DOAD									a/ Route Num	ber, City or Tox	vn, State, Zi	p Code)		
CYNTHIA ROSENBERG / DAUGHTER 6719 OLD PIMLICO ROAD - BALTIMORE, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State														
20a. Method of Disposition 1 Date 20b. Place of Disposition (Name of camatary, cramatory or other place) 20b. Place of Disposition (Name of camatary, cramatory or other place) 20b. Place of Disposition (Name of camatary, cramatory or other place) SWINICHER WOLINER CEMETERY 2/14/99 BALTIMO														
21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS. 8900 REISTERSTOWN ROAD - PIKESVILLE,														
	23a. Part1. Enter th	e disease, or o	omplications the	caused the deer	th. Do not ente	er the mod	de of dyin	g, such as	cardiac	or respiratory	arrest,		Approximate Interval Betwe	
Immadiata Causa (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):														
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	Tak ii. Other signiii	denying	ause giv	on in rait			Yes 2 N							
										24a. Wa	s an autopsy formed?	a	Vere autopsy fine vailable prior to ompletion of cau f death?	
Completed										1□	Yes 20 No	1	□ Yes 200	
0	25. Was case referre	ed to medical	Manital				011		e of Deat	h (Check only	one)			
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	Natural 2 Accident	5 Pending invastiga	(Mc	onth, Day Year)	Injury	м	28c. Injun Worl 1 □	k?` Yas 2□	No	200. 0000100	, now injury ou			
	3 Suicide 4 Homlcida	6 Could no determin	20a. Plai	ce of Injury - At h ding, atc. (Special	ome, farm, stre	et, factor	y, office			28f. Location City or To	(Street and Nu	m <i>ber</i> o <i>r</i> Rui	ral Route Numbe	
and an analysis of the same of	29a. Cartifier (Check only one)		caminer: On the	na best of my kno basis of axamina inner stated.										
E	29b. Signature and t	itla of certifier	anoma	stated.		29	c. License	e number			29d. Date sig	ned (Month	, Day, Year)	
	1000	_ 1	Hand.	Phyci	111	29c. License number					29d. Date signed (Month, Day, Year)			

DHMH 16 Rev 6/95

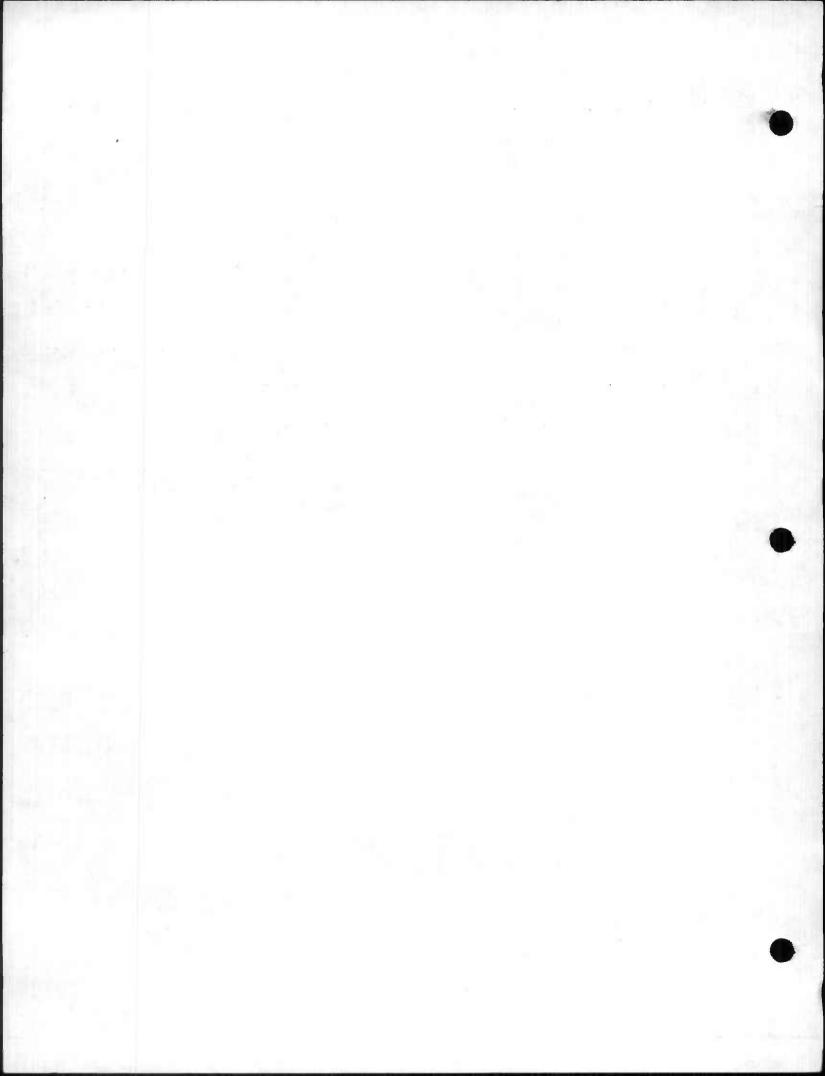


			State of Ma	ryland		artment rtificate				giene G	05	1.97
		1. Decedent'e Name (First, Middle, La	st)						2. Dete of De	ath	Mark	3. Time of Death
Physi /Med		Johanna Hildega	rd Schonfel	ld					Februa	ry 6, 1	999	6:15 AM
Exam		4a Facility Name (If not institution, giv	e street and number)				4	b. City, Town, or	Location of Deat	4c. Coun	y of Death	
		Manor Care - Fe						Bethes			tgome	
Funera Directo		5. Social Security Number 6. S 130–18–0503 1 Usuel Residence of Decedent	ex 7. Age ☐ M 2⊠ F	(In yrs. last	Yrs.	If Under 1 Months	Deys	If Under 24 Hrs Hours Min	8. Date of Bir (Month, Da July 16	th Year) 1908	9. Birth Cou Ger	place (State or Foreign ntry) many
Se-f show offilled at	Director	MD 10b. County MD Montgom		10c. City, T		Spri						10d. Inside City Limits 1 ☐ Yes 2 → No
4 P		10e. Street and Number				10f. Zip (10g. Citizen of		intry?
seth mast	929	3141 Farnborough	12. Was Decedent Ev	ver in II S	13.1		2090		Specify Ves or No	USA 14 Ba	ce - Ameri	can Indian
JUZU ours after death with the Marylar nsi', or items 23s or 28e-f show Exeminer man be notified at	by Funeral	1 Never Married 2 Married 3 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			If Yes, specif			Specify Yes or No to Rican, etc.)	Speci	eck, White,	
5-002 72 hours netural.	pet	15. Decedent's Ed	lucation	1	6a. Dece	dent's Usual	Occupa	ation luring most of wo	rekina	16b. Kind of I	Business/In	ndustry
within then the Me	Completed	(Specify only highest gra Elementary/Secondary (0-12) 12	College (1-4or 5+	-)		rical	retired)	nking	Federa	1 Gov	vernment
be fled tal Hygid d other event, 1	Be	17. Fether's Neme (First, Middle, Last)				1110		18. Mother's Ne	me (First, Middle,	, Maiden Suma	me)	
Should by Mark	To	Karl Teufert						Elise	Potrafk	У		
Maryland d 2 should be the th and Mental Hy T is marked other		19a. Informent's Neme/Reletionship (lural Route Numb			
and and mark		Susan Dahme Okol	ita (grand						ew Drive			
Salumore, I semit. Pages 1 and Department of Health mportant: If them 27		20a. Method of Disposition 1 Burial 2 Cremetion 3 4 Donetion 5 Other (Specify			poli	esition (Nemonetory or other)	rema	tory		20c. Location Alexand	ria,	VA
Demit. Depart Imports any inje		21. Signeture of Funeral Survice Licenter	certo		Но	me, In	nc.	s of Fecility F 500 Un ng, MD	rancis J iversity 20901	. Colli Blvd.	ns Fi West	neral
Physician /Medica Examine	l r	23a. Perf1. Enter the disease, or com shock, or heart feilure. List only Immediate Cause (Finel disease or condition resulting in death)	Conges		Hear	t Fai			c or respiretory e	rrest,	1	Approximate Intervel Between Onset end Death
OX OS/OU, certificate be executed inding physician and use as the burial-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	ue to (or es							-	
death death	sicia	Part II. Other significant conditions of	ontributing to death but	not resultin	a in the u	nderiving car	use give	on in Pert I.	23b. Dld	tobacco use c	ontribute 1	to the cause of death?
v requires that the death certifue been signed by the attending should be detached for use a.	y Phys									Y●● 2□ No		obebly 4⊠Unknown
N 2 0 01	Completed by						f			en autopsy ormed?	av cc	Vere autopsy findings vailable prior to ompletion of cause I deeth?
	LOC LOCAL								10	Yes 2⊠No	1	☐ Yes 2☐ No
VICAL The certificate rector, pag	Be	25. Wes case referred to medical axaminer?						26. Plece of De	eth (Check only	one)		
Of VICE Physician: rithis certific ral director,	2	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient		/Outpatier		_	4 123 Nursing	Home 5 ☐ Resi	dence 6 □O	ther (Speci	ify)
Attanding Port death. Attending Port death. Actor: After the by the funera	ation:	27. Manner of Death 1 ⊠Netural 5 ☐ Pending 2 ☐ Accident Investigation		Year) 28	b. Time of Injury	M 28	c. Injury Work	et :? ∕es 2 □ No	28d. Describe	how injury occu	ırred	
UNISION OT VITA To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certification completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home (Specify)	, ferm, str	eet, fectory,	offica		28f. Location (City or To		ber or Rur	ral Route Number,
To the Hospital of within 24 hours at To the Funeral D completely filled	ledical	(Check only 2 Medical Exam	ysician: To the best of ilner: On the basis of e and manner state	xamination	dge, deeth and/or inv	vestigation, i	in my op	inion, deeth occ	e, end due to the urred at the time,	date end plece	, and due t	to the cause(s)
To To To To	Σ	29b. Signeluro and the or comillar	-					number		29d. Dete sign		
10		30. Name and address of person who o	completed cause of dea	ith (Item 23	a) (Type,		D265	71		Februa	ry 6	, 1999
1.5.00		Irving Mizus, M.D	., 4930 Del	lray A	Avenu	e, Be	thes	da, MD	20814			
		24 Date Blad Meath Day Vand	00 D. 114 - 4	. 0								

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Registrar

FEB 0 9 1999 Beneva G. Sports



State of Maryland / Department of Health and Mental Hygiene Q

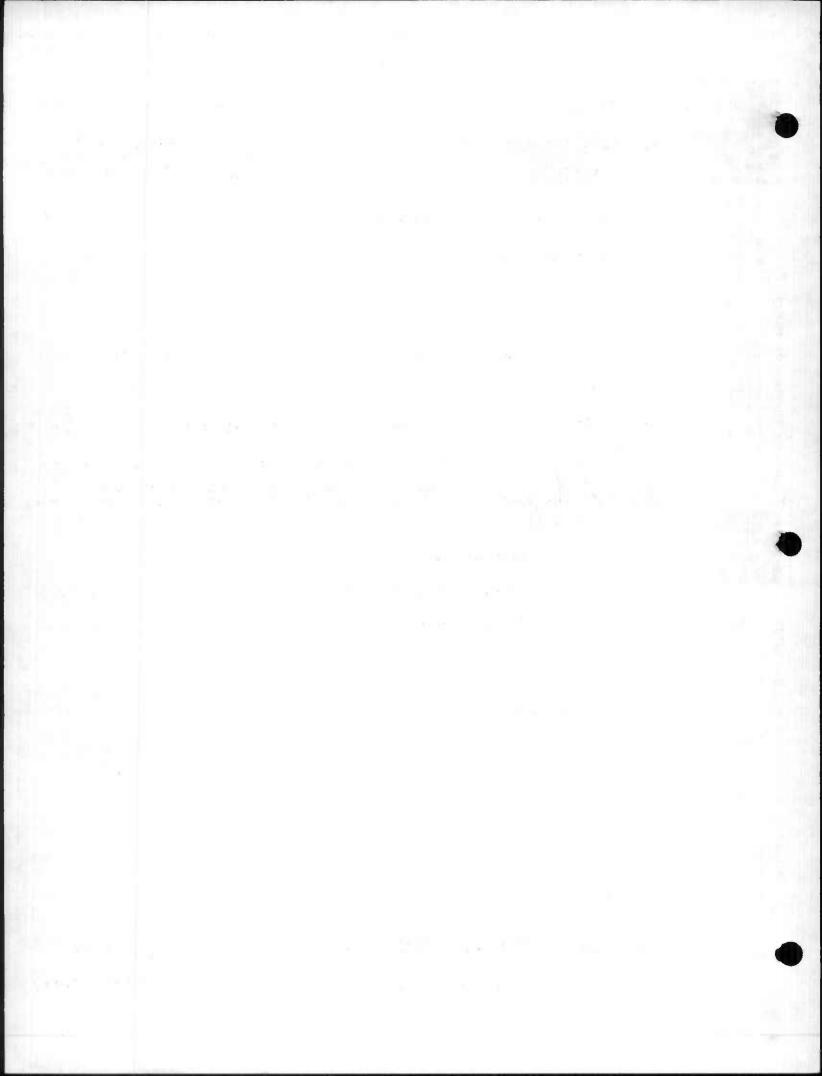
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	5. Social Security	y Number	6. Sex		Age (In yrs.		v) If Unde	r 1 Year	If Under 24 Hrs.		irth	10ntq	OME					
	543-03-		1 🖾 N	/ 2□F	8		Months	Days	Hours Min.	8. Date of B (Month, D April	25,	1916	Wa	shington				
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nu nu	11. Marital Statu			. Was Decede Armed Force	is?	,S. 13	If Yes, spe	dent of h	lispanic Origin? (Span, Mexican, Puert	pecify Yes or N Rican, etc.)	10-		a - Ame	rican Indien, e. etc.				
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To B	Georg	e Schri	ver						Anne	(N	ot	Avail	ahla)				
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	20a. Method of Disposition 20b. Place of Dis																	
	1□ Burial 2 IXCremetion 3 □ Removal from State cemetery, cremetory or other place) Feb. 5, 1999																	
													la, l	Maryland				
	Robert A. Pumphrey Funeral Home/Rockyi												. Tr	20				
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To the Hospital or Attending Physician: The law requires that the death certificete be executed

Division of Vital Records, P.O. Box 68760,

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland

Baltimore, Maryland 21215-0020



State of Maryland / Department of Health and Mental Hygiene

	_			Certificate of	Death		eg. No.	U	11:32					
Physic	ian	Decedent's Neme (First, Middle, Last)				2. Dete of Deet Month	Dey	Yeer	3. Time of Death					
/Medi		Doris 4e. Fecility Neme (If not Institution, give street end number)	Harriet		4b. City, Town, or L	Februar			3:15 AM					
Exami	ner	Brooke Grove Rehabilitation	C 37				4c. County o							
Euparal			(In yrs. lest bir		Sandy Si If Under 24 Hrs.	8. Dete of Birth	Montgo		ce (State or Foreign					
Funeral Director		1□ M 2団 E		Yrs. Months Deys	Hours Min.	Month, Dey,	Year) 1910 N	Country lassac	chusetts					
Maryland f show	or	10e. Stete 10b. County Maryland Montgomery	10c. City, Tow					100	I. inside City Limits					
tha 128s	Directo	10e. Street end Number	Sandy	Spring 10f. Zlp Code		10	0g. Citizen of W	hat Country						
3a or		18430 Brooke Grove Road	•	20860			United :							
2 should be filed within 72 hours efter death with the Manyland and Mental Hygiene. Is marked other than "natural", or flems 23a or 28a-f show raumatic event, the Medical Exameter must be notified at	Funeral	11. Marital Stetus 12. Wes Decedent E		13. Wes Decedent of H If Yes, specify Cube			14. Race Bieck	- American	Indien,					
naf, c	by	3 ☐ Widowed 4 ☑Divorced If Yes, Give Yeer or Deles:		1 ☐ Yes 2 💢 No	Specify:		Specify:	Whit	e					
ithin 72 ho ie. ien "netu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5-))	Decedent's Usuei Occup (Give kind of work done life. DO NOT use retired	petion during most of world)	king	16b. Kind of Bus	siness/indu	stry					
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and 2 s aalth ar n 27 la		Bernard Z. Conn (son)		Trinity Pla					000)					
F Has		20e. Method of Disposition	20b. Plece of	Disposition (Neme of ry, cremetory or other plea	onl		20c. Location - (n, State					
Pega ent o nt: If		1 ☐ Burial 2 【ACremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify)				2-8-99	Reltsvi	11e. 1	Marvland					
Department of Haa Important: If Item, or other once.	21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD													
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Physician /Medical		23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition PNEWMONIA												
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icete be axecuted physician end s tha bunal-transit	Examiner	Sequentially list conditions.		AND DE	HYDRAT	LION			NEEKS					
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ng the land	ation:	27. Menner of Death 1 XNetural 2 \(\text{Accident} \) 5 \(\text{Pending investigation} \) 28a. Dete of Injury (Month, Day)		rime of njury 28c. Injur Wor 1 □	y et rk? Yes 2 □ No	28d. Describe ho	w injury occurre	ed .						
in b	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inju building, etc.	ry - At home, fa (Specify)	rm, street, fectory, office		28f. Location (St City or Town		r or Rural F	Route Number,					
Hospi 4 hou Funer taly fill	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and menner stet	examination en	, death occurred et the tir d/or investigetion, in my o	me, date and plece ppinion, deeth occur	end due to the ce red et the time, da	ouse(s) and man ate end plece, a	ner as state	ed. ne cause(s)					
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3		JEANUR	. M	00	D3370	70 F	EBRUAR	y 8	1999					
		30. Name and address of person who completed cause of de		(Type, Print)					~					
		TED E HOWE 7542		TOOK DEIN	E BOON	515020	MD	2171	5					
Sta Registi		31. Dete filed (Month, Day, Year) FEB 10 1999 32. Begistrer	's Signeture	9. Sparks										

DHMH 16 Rsv 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMENDED BY COURT Office of Maryland 7 Department of Health and Mental Hygiene 9 9 155 11

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	Physic /Medi				Mary Ja	ne Sco	pin				Febru	Day arv 9. 1	Yaar 999	2:20 am		
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Maryland	S D E E		19a. Informant's Name/F	lelationship (Type, Print)		19b. Maili	ng Addras	s (Stree	t and Number or Ru	ber, City or Town	, Stata, Zip	Coda)			
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			30. Nama and address of	person who	completed cause of	deeth (Item 2	3e) (Type,	Print)	. 0 .	. 0	۸۱.	Feb 9	- 00	1		
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Registrar

